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*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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THE WOMAN'S MEDICAL COLLEGE OF PENNSYLVANIA

SCIENTIFIC ARTICLES

Mass Surveys in Case-Finding Techniques for Pulmonary Neoplasms, *Katharine R. Boucot, M.D.* . . . 485
The Present Status of Streptomycin, *Harold L. Israel, M.D.* . . . 493
The Diagnosis of Ruptured Fetal Membranes by the Use of a Simplified Vaginal Smear Technique, *Ann Gray Taylor, M.D., and Joan M. Roberts, M.D.* . . . 498
What is Presymptomatic Cancer and How May It be Diagnosed? *Catharine Macfarlane, M.D., F.A.C.S.* . . 500
Vesical Apoplexy, *Stanford W. Mulholland, M.D.* . . . 502

RESIDENTS' ROUND TABLE

Sarcoidosis (Boeck): A Case Report, *Katheryn L. O'Connor, M.D.* . . . 504

EDITORIAL SECTION

A Notable Record of Service, *Ada Chree Reid, M.D.* . . . 507
Carmen C. Thomas, M.D., *Guest Editor* . . . 507
Cancer Detection and Trends in Medical Practice, *Carmen C. Thomas, M.D.* . . . 508

SPECIAL ARTICLE

Ann Preston: Physician, *Margaret Castex Sturgis, M.D.* . . . 509

INTERNATIONAL SECTION

Campaign against Tuberculosis of the World Health Organization . . . 512
Malaria Control Program of the World Health Organization . . . 513

REGULAR FEATURES

Current Publications of Women in Medicine . . . 514
Book Reviews . . . 517
Opportunities for Medical Women:
A Busman's Holiday, *H. E. Thelander, M.D.* . . . 518
Opportunities for Physicians in Germany and Japan . . . 518
Opportunities for Physicians in United States Civil Service . . . 519

ASSOCIATION NEWS AND REPORTS

Annual Meeting, June 1949 . . . 521
Medical Women's Library and Memorial Fund, *Bertha Van Hoosen, M.D.* . . . 521
News from the Branches . . . 521

NEWS AND ANNOUNCEMENTS

Medical Women in the News . . . 522
Medical Woman of the Month, *Louise Pearce, M.D.* . . . 523
News from the Woman's Medical College of Pennsylvania . . . 524
Obituary . . . 524

Directory of Officers . . . vi
Index of Advertisers . . . xiv
Index for 1948 . . . 525

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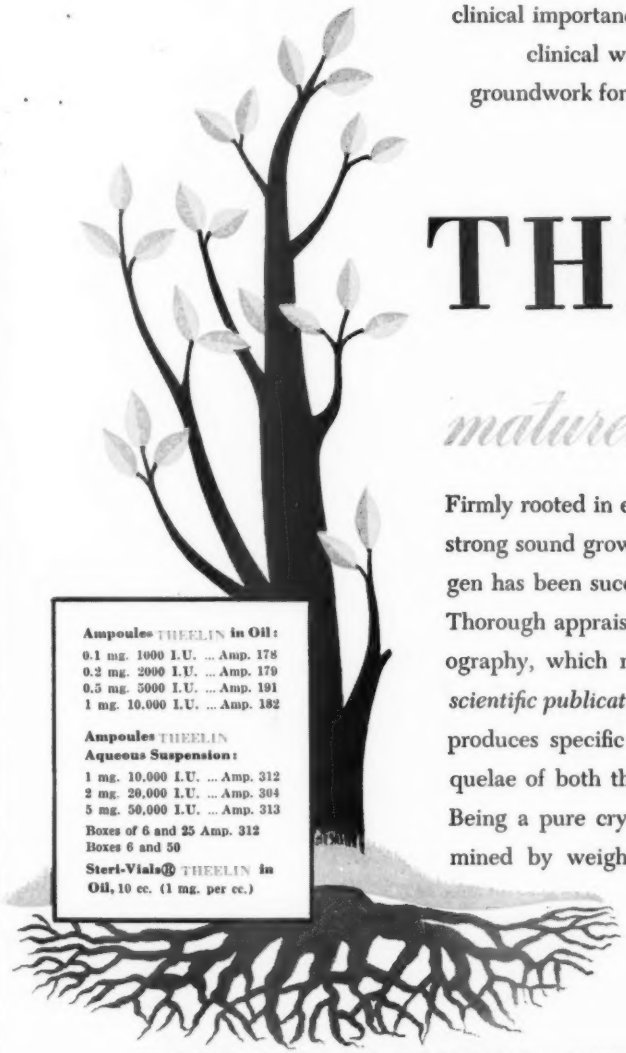

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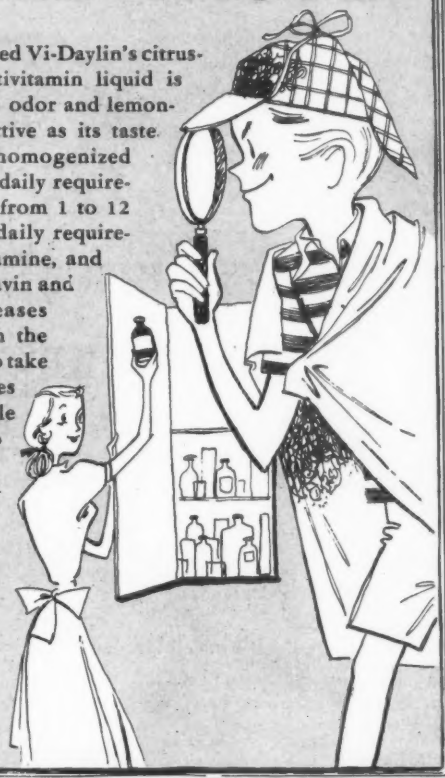

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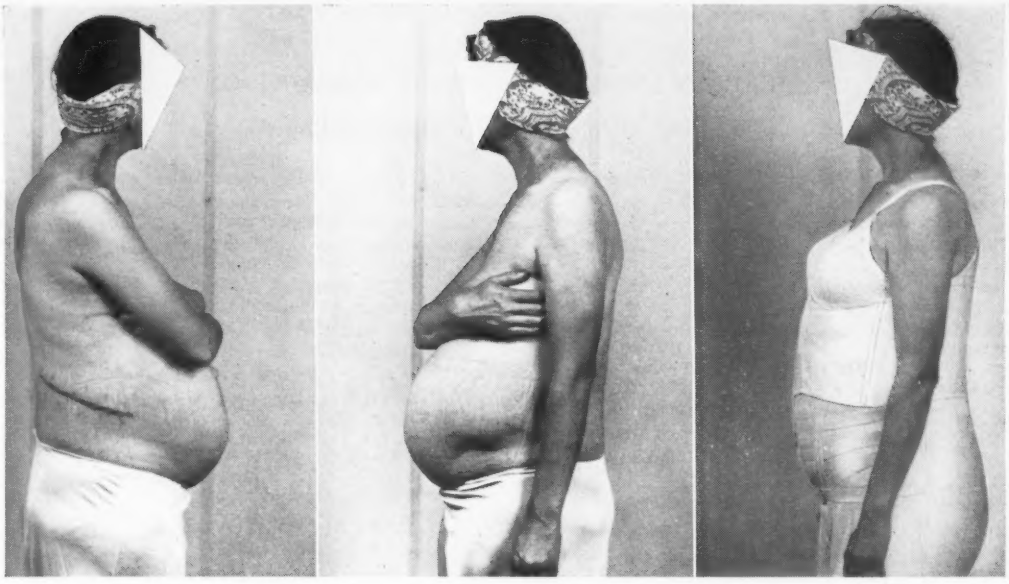

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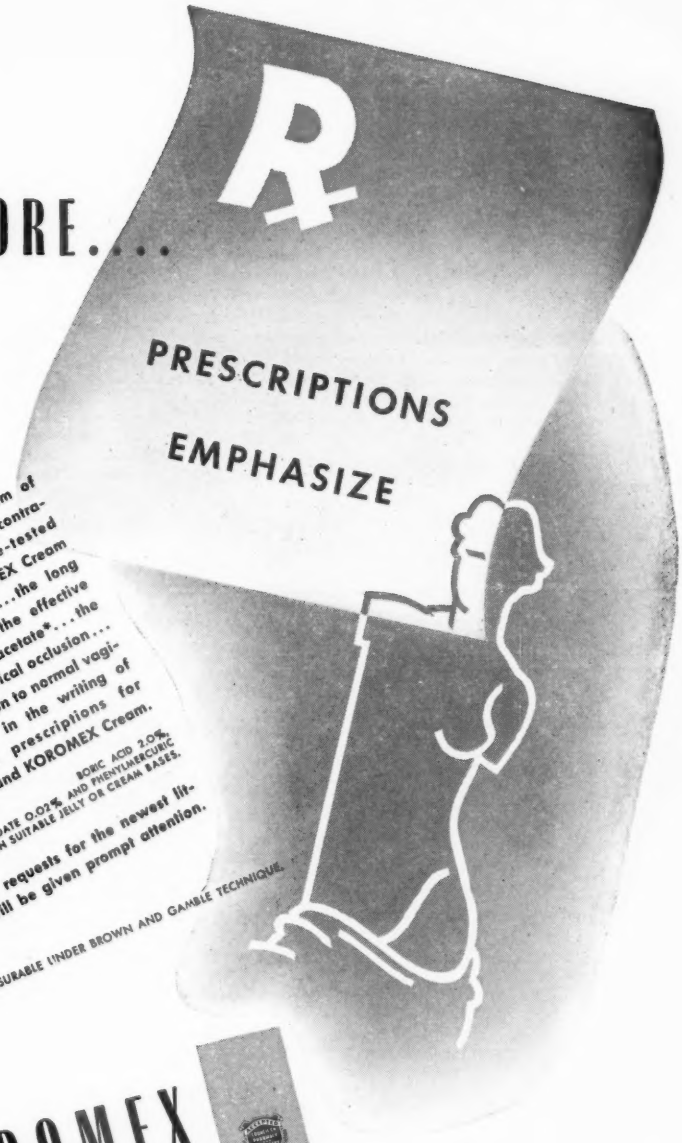

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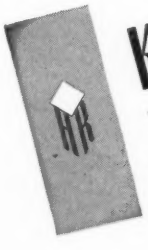

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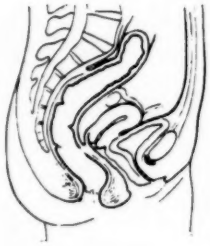

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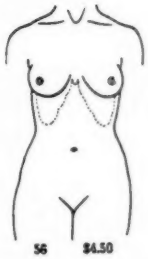

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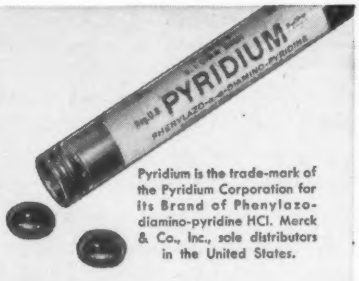

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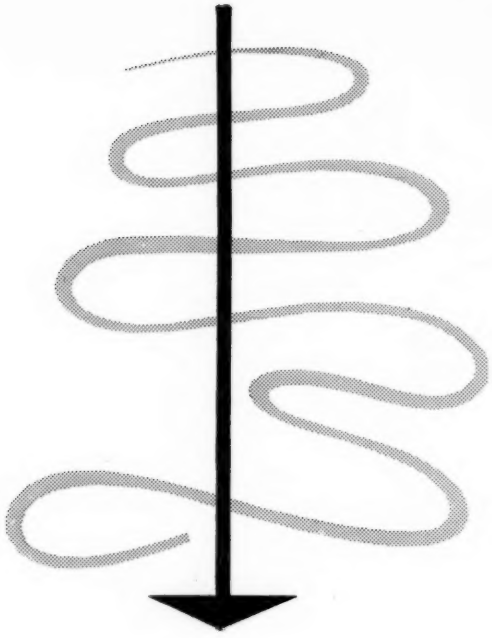

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Mass Surveys in Case-Finding Techniques For Pulmonary Neoplasms

Katharine R. Boucot, M.D.

RECENTLY CHURCHILL[1] pointed out that the surgical techniques for pneumonectomies have been perfected and that further progress in the conquest of carcinoma of the lung must be based on earlier case-finding. To date, the major emphasis in mass surveys has been placed on tuberculosis case-finding. It seems appropriate to stress the fact that photofluorography is also a suitable method for detecting pulmonary neoplasms. Certain fundamental principles must be kept in mind:

1. *Surveys are screening processes, not diagnostic in nature.* Only adequate follow-up makes them effective. Therefore, it is incumbent upon all physicians who receive survey reports on their patients to make an effort to arrive at an accurate diagnosis. This entails more than one 14x17 retake, since a single large chest film is no more diagnostic than a single miniature film.[2] When sputum is available for study the presence of tubercle bacilli yields a prompt diagnosis of tuberculosis but, in the absence of a positive sputum, diagnostic studies often must include tuberculin tests, serial roentgenograms, sedimentation rate, bronchoscopy, examination of bronchial secretions for tubercle bacilli and neoplastic cells, bronchography, planigraphy, examination of pleural fluid for cells and organisms, and even exploratory thoracotomy. Needle biopsy is used successfully

Fig. 1. Case I. 6-29-44: Rounded mass at left base, in which there is an area of rarefaction.

Dr. Boucot is Associate in Medicine, Woman's Medical College of Pennsylvania; Director of x-ray surveys, Philadelphia Tuberculosis and Health Association; and Supervisor of x-ray surveys, Tuberculosis Division of the Philadelphia Department of Health.

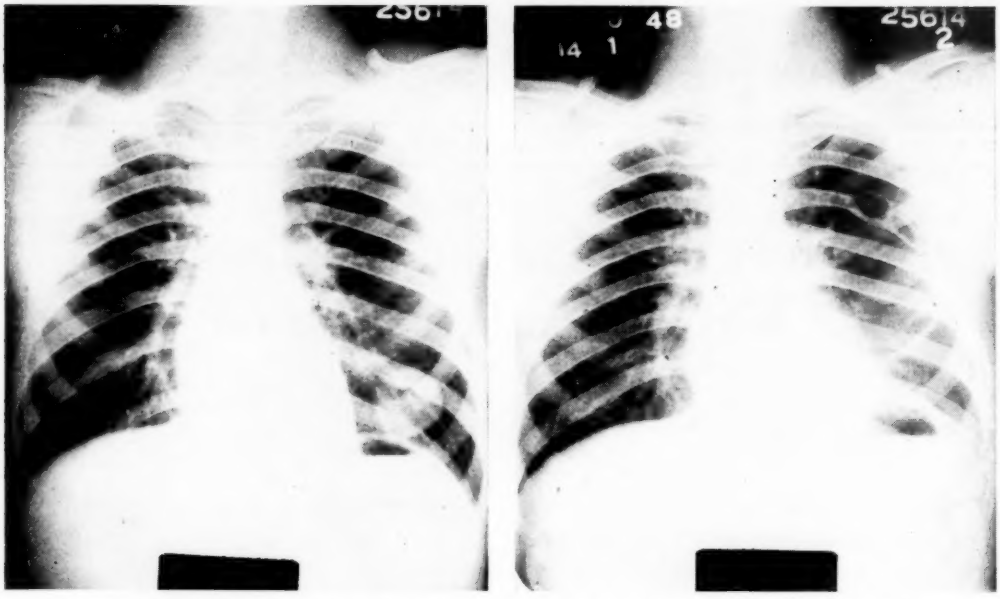

Fig. 2. Case 1. 9-15-47: Mass at left base is larger. 8-30-48: Nine months after left lower lobe segmental lobectomy. Pathological diagnosis: mucoid adenoma.

in some clinics.[3] Diagnostic pneumothorax is occasionally helpful.

Case 1 demonstrates the need for meticulous follow-up. M. C., a 16-year-old white male student, had a pre-employment photofluorogram, June 29, 1944. (Fig. 1) A rounded mass was noted at the left base. In this lesion there was a small central area of rarefaction. The young man had not been employed by the firm to which he had applied for summer work and the family had moved so that the follow-up did not catch up with him until July 11, 1945, when he was re-rayed. No change from the earlier film was noted. He was interviewed and found to be asymptomatic, having been a five-letter man on his high school teams during 1944-45. He was intelligent and co-operative so that, despite his well-being, he was willing for arrangements to be made for his admission, September 17, 1945, to Temple University Hospital on the chest service.* Bronchoscopic examination revealed no pathology. Bronchial secretions and sputa were negative for tubercle bacilli. The tuberculin test was negative. The patient was discharged with a tentative diagnosis of tuberculoma. He was followed intermittently by x-ray and on September 15, 1947, a check-up revealed a slight increase in the size of the lesion at the left base. (Fig 2) It was therefore decided to proceed with thoracotomy. The patient was readmitted to Temple University Hospital, October 23, 1947. He was asymptomatic; physical examination was negative. A needle biopsy was performed which was not diagnostic but suggested the possibility of tuberculoma. Laboratory work on admission: 14 gm. hgb., 4,600,000 R. B. C., 13,000 W. B. C. with 88 per cent polys. Blood serology was negative and the blood sugar was 109 mgm. percent. On November 4, 1947, a left lower lobe segmental lobectomy was performed. A tumor of 7 cm. diameter was found near the interlobar fissure. It was separated with relative ease except for a few firm attachments. It contained an extremely viscid material so unusual in appearance that a frozen section was requested. The first impression suggested gastro-intestinal tract mucosa so that

*We are indebted to Dr. Louis Cohen and Dr. George P. Rosemond for the clinical data on this case.

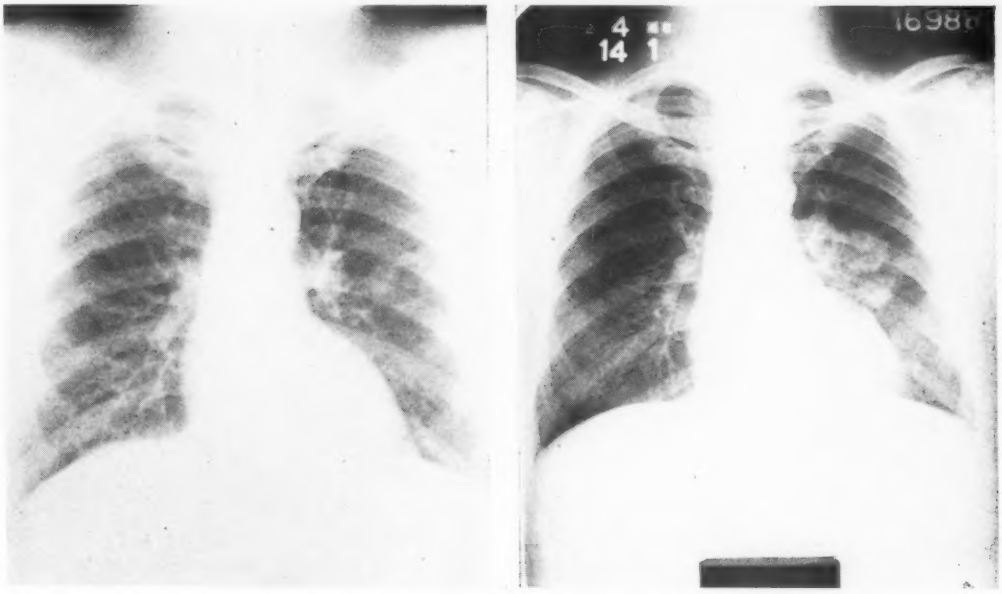

Fig. 3. Case 2. 2-21-47: Infiltration right third interspace. 2-4-48: Three rounded masses at left hilum one year later. Death seven months later. Autopsy revealed squamous cell carcinoma of bronchus with cerebral metastases.

a tentative diagnosis of teratoma was made. Subsequent pathological study yielded a diagnosis of mucoid adenoma. The postoperative course was uneventful. This boy has remained well. His film of August 30, 1948, revealed no recurrence so that we have here a rare case of focal adenomatosis possibly saved from dissemination by persistent serial x-ray follow-up and surgical intervention.

2. *Any persistent pulmonary infiltration not definitely diagnosed as tuberculous should be considered potentially malignant.* This concept should be as acceptable as the well established one by which all pleural effusions have come to be considered tuberculous unless proven otherwise. Cases 2 and 3 illustrate the wisdom of this attitude.

Case 2. J. B., a 47-year-old white male, had the routine photofluorogram required annually on all Philadelphia foodhandlers, February 21, 1947. (Fig 3) It revealed infiltrations in the left third anterior interspace. In the absence of symptoms these were thought to represent an old tuberculosis of no present significance. No serial retakes were made, but one year later at the routine examination, February 4, 1948, three large rounded masses were plainly visible in the region of the left hilum. Unfortunately, even when x-ray changes made the likelihood of malignancy unequivocal, this patient refused admission to a hospital for therapy because of the absence of symptoms. Seven months later, in September 1948, he was admitted to a hospital because of headache. He became psychotic and developed a left hemiparesis. He was transferred to Philadelphia General Hospital where he died, September 19, 1948. Autopsy revealed squamous cell carcinoma of the bronchus with cerebral metastases.

Case 3.* J. W., a 51-year-old white machine operator, was x-rayed in an industrial survey, June 24, 1946 (Fig. 4), at which time a homogeneous nodule was noted in the right sixth interspace.

*We are indebted to the United States Public Health Service for permission to include this case. Follow-up was through the Central Cooperative Clinic, a joint research project of the United States Public Health Service, the Philadelphia Department of Health, Division of Tuberculosis, Temple University School of Medicine, and the Philadelphia Tuberculosis and Health Association.

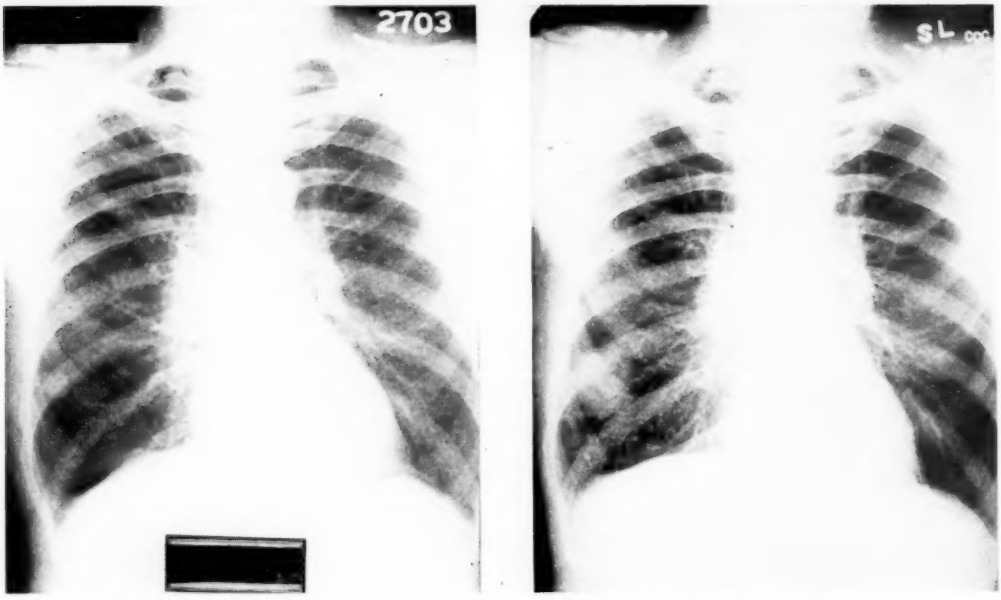

Fig. 4. Case 3. 6-24-46: Nodule right sixth interspace. 9-20-47: Fifteen months later. Nodule larger in size. Patient had a pneumonectomy. Pathologic diagnosis: squamous cell bronchogenic carcinoma, grade II.

On August 6, 1946, his physical examination was essentially negative. He gave a history of "pneumonia" on the right side in 1942, at which time he was told he had fluid present in his chest. He had fatigue for two to three years, and cough productive of one-half cup sputum daily for years. His tuberculin test was positive and his histoplasmin test negative; Wassermann was negative; blood count was 16 gm. hbg., 4,910,000 R. B. C., 9,050 W. B. C., with 67 percent polymorphonuclear cells. Consecutive sputum specimens were negative for tubercle bacilli on smear and culture. The patient was followed every three months by x-ray and sputum studies. The nodule at the right base increased slightly in size. Needle biopsy on October 2, 1947, revealed malignancy. A right pneumonectomy was performed. The tumor was a squamous cell carcinoma, bronchogenic, grade II. He is living and well one year postpneumonectomy.

3. *Time is extremely important if the diagnosis of malignancy is to be reached soon enough for a cure.* Too frequently survey cases are followed for long periods of time in order that tuberculosis be ruled out, only to find that the ultimate diagnosis of carcinoma is obtained so late that the case is already inoperable.

Case 4. K. C., a 60-year-old dishwasher, had a routine foodhandler's photofluorogram on April 10, 1947. (Fig. 5) There were infiltrations present in the right first and second interspaces. On April 28, 1947, he stated that he had consulted a private physician two months before because of increasing cough, occasional bloody sputum, loss of thirty pounds over a two-year period, and fatigue of three months' duration. The physician reported that the patient had been afebrile without abnormal physical signs and had had a normal sedimentation rate and sputum negative for tubercle bacilli. Bed rest had been recommended because of infiltrations and fibrosis in the right lung but the patient had refused. In May 1947, following the survey film report, the private physician hospitalized the patient at Philadelphia General Hospital on the tuberculosis ward. No change in the pulmonary lesions was demonstrable. Five sputa and several gastric washings were re-

Fig. 5. Case 4. 4-10-47: Infiltrations in right second and third interspaces. 7-13-48: Marked involvement of right hilum and base with increase in parenchymal infiltrations and elevation of right diaphragm due to phrenic nerve involvement. Biopsy from right bronchus: squamous cell carcinoma. Sputum also positive for tubercle bacilli.

ported negative for tubercle bacilli. Bronchography failed to reveal bronchiectasis as an explanation for the x-ray changes in the right lung. Therefore, the private physician recommended that the patient be discharged from the hospital and allowed to return to work as a foodhandler. The patient did not return to his private physician but subsequently reported to a chest clinic connected with one of our teaching institutions. A summary of the follow-up received from that institution is presented:

"Sputum negative on concentration, July 23, 24, and 31, and September 13, 1947. Signs and symptoms: cough, at times severe; sputum; underweight. Diagnosis: tuberculosis suspect, suspect neoplasm. To return immediately for further study. July 29, 1947: therapy conference report: 'The conference believes that a recommendation at this time is not justified in view of the fact that the iodized oil makes accurate interpretation of the single film difficult. It is suggested, however, that sputum examination by concentration culture be carried out, that the patient be encouraged to practice postural drainage for a period of ten days, and that a retake then be made. It is also suggested that the films be obtained from the Philadelphia General Hospital and the case be represented to conference at that time.' March 30, 1948: report on x-ray film taken February 26, 1948. There is a well-marked increase in density of shadow at the pulmonary hilum and in the upper third of the right lung. The x-ray examination is atypical of tuberculosis and strongly suggests the presence of bronchial carcinoma in spite of slight weight gain. Please do all tests and present to Therapy Conference. From an x-ray standpoint a diagnosis of bronchial carcinoma is justified. Bronchoscopic examination is indicated.' Sputum negative. Treatment recommended: observation. Patient able to work? Yes. When is patient to return for examination? In one month. Remarks: Non-tuberculous."

On April 9, 1948, the patient was finally admitted to a hospital where a diagnosis of squamous cell carcinoma of the right bronchus was made. Bronchoscopic aspirations were also positive for acid-fast bacilli, as were three sputum smears. Thus both tuberculosis and carcinoma were present in this case. There was evidence that the tumor had invaded the trachea but the chest surgeons were still willing to explore the patient. However, surgery was refused. He was committed to the Philadelphia Hospital for Contagious Diseases by court order, August 12, 1948. The patient in this instance was obviously not co-operative but, even had he been, definitive diagnostic studies were not recommended for one year after the survey film revealed pathology and fourteen months following the onset of symptoms. How much his early experience conditioned him to resist subsequent recommendations and how disheartened he became through long months of observation remain problematic.

In contrast to the dismal failures which result

Fig. 6. Case 5. 12-5-47: Homogeneous wedge-shaped infiltration at left apex. Patient had a left pneumonectomy. Pathological examination revealed squamous cell carcinoma.

from procrastination, bold surgery on cases in which the survey film strongly suggests malignancy will result in a higher percentage of cures.

Case 5. O. P., a 58-year-old white male carpenter, presented himself for x-ray at our Central Unit, December 5, 1947 (Fig. 6), at which time a rather circumscribed lesion was seen to swing up from above the left hilum toward the left apex. This was read as a probable malignancy and the patient had a pneumonectomy on December 31, 1947. He is well ten months postpneumonectomy. Pathological diagnosis was squamous cell carcinoma of the left bronchus.

4. *Periodic x-ray check-up should be routine for all adults.* The exact interval that is best is somewhat problematical. We advocate rather arbitrarily annual chest x-rays for all adults. Certainly all hospital admissions and clinic patients should receive chest x-rays routinely and at stated intervals. It is a shocking thing to run into an inoperable pulmonary malignancy in an individual regularly attending a hospital clinic.

Case 6. J. S., 70-year-old white male diabetic, reported to the Philadelphia Diabetic Survey for chest x-ray, April 12, 1946. (Fig. 7) He was found to have a huge mass in his upper right mediastinum. This was read on the survey film

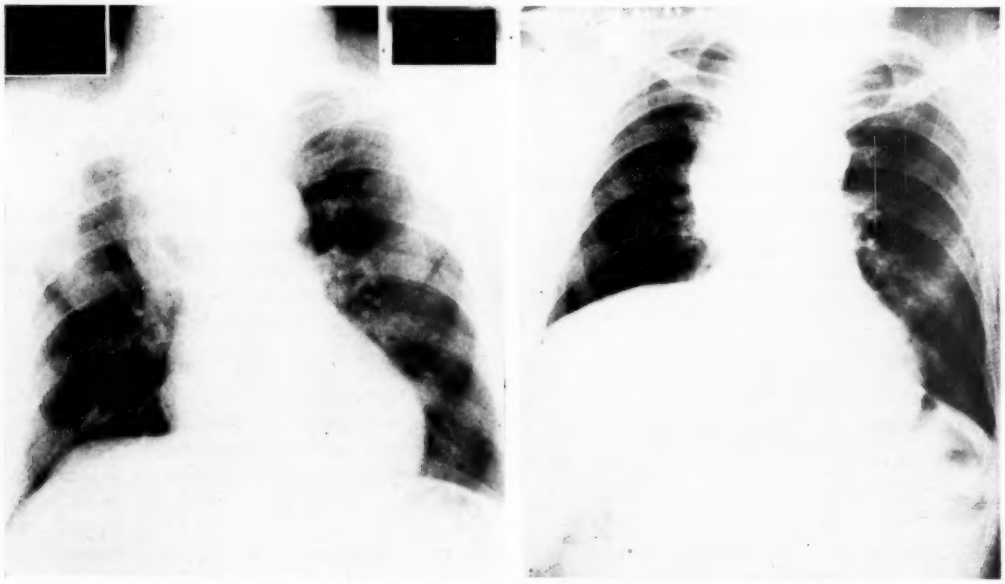

Fig. 7. Case 6. 4-12-46: Huge mass in upper right mediastinum. 8-13-46: Marked elevation of right diaphragm due to involvement of phrenic nerve. Film was taken one day before patient died. Autopsy revealed bronchogenic carcinoma.

as strongly suggestive of neoplasm. He was asymptomatic until June 1946, when he developed blood-streaked sputum daily. On August 13, 1946, a film revealed marked elevation of the right diaphragm pathognomonic of metastasis to the phrenic nerve. He died on August 14, 1946. Autopsy confirmed the survey disgnosis of bronchogenic carcinoma. This man had been regularly attending a diabetic clinic in a teaching hospital.

Philadelphia x-ray surveys are largely under the jurisdiction of the Division of Tuberculosis in the Department of Health and under the Tuberculosis and Health Association. Thus, budgetary considerations have not allowed the setting up of statistically accurate records on the prevalence of survey carcinoma. However, beginning August 1, 1948, at the Tuberculosis and Health Association we have recorded "suspect neoplasm" on films in any way suggestive of new growth. In other words, where emphysema suggesting obstruction, mediastinal enlargement, atelectasis, soft infiltration or cavity associated with mediastinal shift or parenchymal mass have been present, we have classified the film as "suspect neoplasm" as well as "probable tuberculosis." This system has obvious disadvantages but it is a start toward using mass surveys more effectively for uncovering pulmonary malignancies. It is a conservative approach since some cases read only as tuberculosis ultimately prove to be neoplasms. The following figures have been obtained from August 1 to September 17, 1948:

	Total X-rayed	Suspect Neoplasm	Percentage
Central Unit*	1747	4	0.2
Industrial Unit**	4607	7	0.2
Total	6354	11	0.2

*A centrally located unit to which individuals come of their own accord or are referred by private physicians and by industrial plants.

**A mobile unit moving from plant to plant.

Gould[5] in 1945 called attention to the fact that with the increasing prevalence of neoplastic diseases mass x-ray surveys would undoubtedly assume an increasingly important role in early diagnosis. In an analysis of 442,252 individuals examined by mass x-rays by the United States Public Health Service in 1944, he gave a figure of 1.1 to 6 percent as the prevalence of a abnormal non-tuberculous findings. Of these some 138 could be considered as pulmonary neoplasms, representing 0.03 percent.

Prior to August 1, 1948, no follow-up was maintained at the Philadelphia Tuberculosis and Health Association on cases with survey readings of non-tuberculous disease. As the usefulness of surveys for carcinoma case-finding became apparent, a casual record has been kept over the last seven months of follow-up information coming in on cases read as "probable tuberculosis," but clinically proven or suspected malignancy. The following information has no statistical importance but convinced us of the need for a more accurate study:

	No. of cases
Carcinoma suspects under observation	32
Successful pneumonectomies (patients living and well for various periods of time)	7
Pneumonectomy, patient dead	1
Proven bronchogenic carcinoma awaiting surgery	1
Carcinoma proven inoperable, patient still living	8
Carcinoma proven inoperable, patient dead	12
Carcinoma suspect, clinically diagnosed carcinoma, patient dead	1
Adenomatosis, for which segmental lobectomy was successfully done	1
Metastatic carcinoma	7
Secondary to:	
Carcinoma of breast	1
Epidermoid carcinoma of cheek treated 5 years previously	1
Gastric carcinoma	1
Adenocarcinoma of sub-maxillary gland	1
Carcinoma of pancreas	1
Primary site unknown	2
Mixed tumor of bronchus for which lobectomy was successfully done	1
Substernal thyroids removed (Of these one revealed malignant change. This patient is living and well two years postoperatively.)	3
Tumor of rib, supposedly benign, so-called "fibrous dyspasia"	1
Mediastinal tumors	5
Dermoid, successfully removed	1
Hodgkin's mediastinal	2
Suspect neurofibroma	1
Lymphoblastoma, awaiting accurate diagnosis	1
Total	80

With the feasibility of resecting solitary metastases, the category "metastatic malignancy" has become of more than academic interest.

Summary

1. Mass chest x-ray surveys are suitable case-finding techniques for detecting pulmonary neoplasms provided they are recognized as screening

processes and adequate diagnostic studies are instituted.

2. Any persistent pulmonary infiltration not definitely diagnosed as tuberculous should be considered potentially malignant.

3. Time is extremely important if the diagnosis of malignancy is to be reached soon enough for a cure.

4. Periodic chest x-ray check-up should be routine for all adults.

5. Six illustrative case histories have been presented.

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The Present Status of Streptomycin

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UNDOUBTEDLY PENICILLIN remains the antibiotic of greatest therapeutic value but streptomycin has already proved a worthy second. Increased supplies and progressive reductions in the cost of the drug have permitted its widespread use in susceptible systemic infections, meningitides, and urinary tract infections, as well as in various forms of tuberculosis.

In the early use of streptomycin, two obstacles were recognized, toxicity and the development of drug resistance. Greater purification of the drug and the use in prolonged administration of smaller doses have led to the realization that streptomycin is a drug of relatively low toxicity.

Streptomycin Resistance. The rapidity with which organisms become resistant to streptomycin remains an important defect of this drug. Despite extensive investigation the fundamental mechanisms responsible remain unknown. It has been demonstrated that resistance develops much more rapidly to streptomycin than to penicillin or sulfonamides and that organisms which have become tremendously resistant to one of these drugs retain their original susceptibility to the others.[1] It has also been shown that resistant organisms appear by growth from small numbers of resistant bacilli, which can be demonstrated by suitable dilution techniques to be present even in highly susceptible strains;[2] but the same ratio of resistant colonies to susceptible colonies has been found in patients whose infections were rapidly cured as in some patients whose organisms rapidly acquired resistance.[3] Although resistance to streptomycin develops with rapidity both *in vivo* and *in vitro*[4] the phenomenon is also conditioned by the host. Thus, tubercle bacilli in a human receiving streptomycin rapidly become drug resistant, while in the treated guinea-pig resistant forms are only occasionally demonstrable.[5] An interesting observation has been that organisms may come eventually to require streptomycin for growth.[6]

Two observations concerning the development of streptomycin resistance have immediate clinical applicability. Harris and his associates[7] observed that the development of resistance in organisms responsible for urinary tract infections was markedly retarded when the urine was kept alkaline. Klein[8] showed that addition of sulfadiazine to streptomycin retarded the growth of streptomycin-resistant variants of Staphylococcus aureus.

Administration. Streptomycin is at present available as the hydrochloride, the sulfate, and the calcium chloride complex, stable indefinitely in dry form, freely soluble, and stable in solution in the refrigerator for a week. Intramuscular injection is the method of choice for parenteral use, and is borne without discomfort by some patients; but for others the addition of 0.25 cc. of 1 percent procaine to each cubic centimeter of streptomycin solution is advisable. Streptomycin may also be administered when indicated, orally, intrathecally, and by aerosol inhalation.

Tularemia. Pasteurella tularensis is so sensitive to streptomycin that bactericidal effect is obtained with extremely low dosage. Foshay[9] recommends a dose of 0.5 gm. for a total of six days. The pneumonic form, hitherto fatal in a majority of instances, responds swiftly to the same dosage. Hunt[10] and Morgan[11] have reported a series of twenty-seven cases of pleuropulmonary tularemia with but one death. Their suggestion is that in endemic areas all patients with severe pneumonia not responding to other measures be given a trial of streptomycin without waiting for bacteriological or serological evidence of tularemia.

Brucellosis. Brucella are moderately sensitive to streptomycin in vitro but clinical results have been disappointing. Significantly better results have been obtained by the combined use of strep-

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tomycin and sulfonamides and this now is the treatment of choice of brucellosis.[12,13]

Miscellaneous Bacteremias. An experience with ten cases of Salmonella bacteremia in the Army study[14] demonstrated the value of streptomycin. Bacteremias due to a variety of gram-negative bacilli are being encountered with increasing frequency. Possibly this is the result of the suppressive effect on other organisms of penicillin therapy. Stanley[15] has reviewed the subject of Pseudomonas aeruginosa (pyocyaneus) infections and reports streptomycin of limited value in overwhelming infections. Nevertheless, streptomycin together with sulfonamides should be the treatment of choice in this and similar bacteremias.

Meningitis. Haemophilus influenzae meningitis has been treated with considerable success. Paine[16] treated eighteen infants and children, with but a single death. Alexander[17] recommends in severe cases the concomitant use of sulfadiazine. In infants less than seven months of age, specific rabbit antiserum is also employed. Weinstein[18] has emphasized the need of vigilance for possible secondary invasion by gram-positive organisms not sensitive to streptomycin. Hence, all patients with Haemophilus influenzae meningitis should receive penicillin in addition to streptomycin and sulfadiazine.

Pseudomonas aeruginosa (pyocyaneus) meningitis has been reported as no longer a rare sequel to lumbar puncture, whether performed for diagnosis or for spinal anesthesia. Several workers have observed cure in such cases with streptomycin.[19] Successful treatment with streptomycin has also been reported in cases of meningitis due to Proteus Morgani, Klebsiella pneumoniae, and pleuropulmonary organisms.

Respiratory Infections. The principal pneumonias caused by streptomycin-sensitive organisms are those caused by Haemophilus influenzae and Klebsiella pneumoniae. Streptomycin was used by Harris and his associates[20] in three cases due to each of these organisms, with cure in one and marked symptomatic improvement in others. In one failure, the organisms cultured at necropsy were drug-sensitive; whereas in three patients a marked clinical improvement ensued, even though the organisms became drug-fast. Olsen[21] reported twenty-seven patients who had bronchiectasis in which significant gram-negative organisms were demonstrated and who were treated with streptomycin aerosol. Symptomatic improvement and reduction in sputum were definite in most cases.

Bacterial Endocarditis. Hunter[22] reported streptomycin treatment in six cases of bacterial endocarditis (three due to penicillin-resistant streptococci, one due to Pseudomonas aeruginosa, and two due to unidentified gram-negative bacilli), with four deaths. He also reported twelve similar cases treated in other clinics, with six deaths.

Urinary Tract Infections. An important advance in streptomycin therapy of urinary tract infections was made by Harris and co-workers,[7] who, in confirming the observation that streptomycin activity was enhanced in an alkaline medium, noted also that the development of resistance in alkaline urine was inhibited. Other investigators,[23,24] utilizing sodium bicarbonate or citrate in 2 gm. doses every four hours to maintain an alkaline urine, have reported in a large series results much superior to those previously found. Marked improvement or cure was noted by Kane and Foley[24] in all cases due to susceptible organisms in which no structural damage to the urinary tract was present and in 87 per cent of cases in which damage was present. Persistence of bacteriuria after seventy-two hours indicates that drug resistance has developed but clinical improvement may nevertheless be obtained. A dose higher than 2 gm. of streptomycin daily is no more effective in obtaining quick sterilization and prevention of resistance. A dose of 1 gm. daily will, if fluids are restricted to 2500 cc., give an adequate therapeutic level in the urine of 100 micrograms per cubic centimeter.

Venereal Disease. The recent demonstration of the bacillary cause of granuloma inguinale led to a trial of streptomycin in this disease which had long been treated with antimony compounds. Dramatic retrogression of chronic lesions has been observed[25,26] after a few treatments and there is little doubt that streptomycin will supplant the older methods of therapy.

Tuberculosis. A fascinating account of the development of chemotherapy in tuberculosis has been given by Waksman.[27] Streptomycin has proved incomparably more effective in tuberculosis than any drug previously known, but that the trail is far from ended is indicated by the demonstration in experimental tuberculosis of a synergistic action with streptomycin of two chemicals, the sulfones[28] and P-aminosalicylic acid.[29]

As to the mechanism of the action of streptomycin in tuberculosis, a demonstration of fundamental importance was reported by Steenken.[5] Streptomycin administered to animals before and after experimental infection did not inhibit multiplication of tubercle bacilli until six weeks elapsed and an allergic response to tuberculin developed. The natural mechanisms of resistance to tuberculosis are apparently essential to the bacteriostatic action of streptomycin.

Even more than in the case of acute infections the two obstacles to the successful use of streptomycin in tuberculosis have been the toxicity of the drug and the rapidity with which the tubercle bacillus becomes drug-resistant.

The problem of streptomycin toxicity in the treatment of tuberculosis has been dramatically reduced by the demonstration that smaller subtoxic doses are equal in therapeutic efficacy to the larger and frequently toxic doses in schedules originally used. In experimental animals, study has shown that the therapeutic effect of streptomycin is not correlated with the blood level of the drug. Thus Feldman, Hinshaw, and Karlson[30] found the therapeutic effect in guinea pig tuberculosis to be as great from a single daily administration given only in alternate weeks as from the same amount of drug given every six hours continuously. Corpor and Cohn[31] similarly observed the same results in animals given streptomycin once every five days as in those given daily injections.

In many forms of human tuberculosis, observation indicates that results with a total daily dose of 1 gm. are as satisfactory as those previously observed with a dose of twice or thrice this amount, and that there has been a reduction in frequency of toxic vestibular symptoms from over 90 percent to less than 30 percent.[32] The clinical results and frequency of toxicity are apparently much the same whether the daily dose of 1 gm. is given as a single injection or in two or four divided doses. It is not yet known whether the rate of development of drug resistance of tubercle bacilli is altered by the smaller dose.

Numerous clinical studies of the effectiveness of streptomycin in tuberculosis have appeared.

Acute Miliary Tuberculosis. McDermott[33] has reported a study of thirteen patients with generalized hematogenous tuberculosis. Striking clinical improvement occurred in most instances within seventy-two to ninety-six hours. Five patients, however, developed tuberculous meningitis which was fatal, and later recurrences developed in four instances associated with drug fastness, while prolonged remission was obtained in four patients. These results are remarkable in a disease previously uniformly fatal but indicate that acute disseminated tuberculosis is still a serious therapeutic problem. Use of 2 gm. of streptomycin daily is advisable, despite the frequency of toxic changes at this dose level.

Tuberculous Meningitis. Meningitis occurring as a complication of acute miliary tuberculosis remains uniformly fatal, but under other circumstances recovery or prolonged remission is not infrequent. Such remissions were obtained in two of McDermott's patients[33] and in four of six children treated by Paine and his associates.[10] Restrictions of intrathecal doses to a maximum of 50 mg. has reduced the frequency of toxic manifestations.

Pulmonary Tuberculosis. The therapeutic results of streptomycin are readily assayed in acute forms of the disease, but extreme care and prolonged observation are required for evaluation of the results in chronic pulmonary tuberculosis. The difficulty of obtaining matched controls in evaluating therapy of tuberculosis is also evident. Jenkins and others[34] carefully studied a group of forty-five patients with apparently fresh tuberculous infiltrations. Half were treated with streptomycin and the remainder by bed rest alone. Roentgenographic clearing was more constant and prompt in the treated group and bacteriological conversion distinctly more frequent. These results were obtained with a dose of 2 gm. maintained for ninety days. Muschenheim and his associates[35] treated thirty-six patients, of whom half had fresh tuberculous infiltrations and half had chronic lesions. Clinical and roentgenographic as well as bacteriological improvement was noted in a majority of patients with fresh lesions and in some patients with chronic disease. It is generally agreed

that streptomycin is in no sense a substitute for older methods of treatment but may be a useful supplement to these forms of treatment in many cases. Patients with minimal disease having a good prognosis should not be given streptomycin if their progress is satisfactory. Acute tuberculous pneumonias may rapidly respond clinically to streptomycin and may be converted into cases suitable for collapse therapy. Difference of opinion exists concerning the value of streptomycin in connection with thoracoplasty and pulmonary resection but Glover, Claggett, and Hinshaw[36] and the experience in Veterans Administration hospitals[37] suggest that the preoperative and postoperative use of the drug may decrease the frequency of spread following surgery.

Laryngeal and Tracheobronchial Tuberculosis. All observers agree as to the striking benefits of streptomycin in laryngeal and tracheobronchial tuberculosis. Black and Bogen[38] report thirty-four cases of laryngeal tuberculosis, with healing in thirteen and improvement in seventeen. In some instances the laryngeal disease improved while the pulmonary disease grew worse. Brewer and Bogen[39] report striking improvement in tuberculous tracheobronchitis with parenteral streptomycin or combined parenteral and aerosol treatment. Results were not as satisfactory with aerosol therapy alone.

Genitourinary Tuberculosis. Streptomycin in the Veterans Administration study[28] has been of benefit when used in conjunction with surgery for renal and genitourinary tuberculosis.

Tuberculous Sinuses. Brock[40] has reported a series which indicates the excellent results in healing of fistulas. Sinuses of many years' duration will as a rule respond promptly to streptomycin therapy. Closure is as prompt with doses of 1 gm. and less as with larger doses.

Tuberculosis of Other Organs. Although no reports of extensive study have appeared the use of streptomycin for tuberculous enteritis, adenitis, and osteomyelitis appears rational.

Streptomycin Toxicity. The principal toxic manifestations have been vestibular dysfunction and cutaneous eruptions. Deafness has proved to be an extremely rare manifestation and has not been observed except in cases of meningitis or in cases where renal insufficiency may have resulted in excessive blood levels of the drug. Loss or impairment of vestibular function occurred in more than 90 percent of patients receiving 2 gm. or more of the drug daily for more than three weeks. The exact site of damage, whether in the nerve or nuclei, has not been established.[41] Most patients are able to compensate so that the vestibular impairment is not recognized and improvement in function occurs to some degree after cessation of therapy. Nevertheless, the complication is not an innocuous one, and the reduction in frequency of vestibular impairment noted with reduced doses is a significant advance. Fowler, in a recent paper on the vestibular nerve damage produced by streptomycin pointed out that it is "an ill wind that bloweth no man good." He reported promising results from the use of streptomycin in the treatment of intractable Ménière's disease.[42]

Cutaneous manifestations during streptomycin therapy are not uncommon but are rarely severe and rarely necessitate interruption of treatment. Incapacitating dermatitis, produced by sensitization in the course of preparing streptomycin solutions, is frequent and is a serious problem to nurses[43] and laboratory workers.

Length of Treatment. In the early clinical studies on the use of streptomycin in tuberculosis dosages of 2 to 3 gm. were given for periods of three months or longer. It became apparent by the end of three months that tubercle bacilli were in most cases strongly resistant to streptomycin. Recent studies indicate that the development of resistance occurs in most patients between the sixth and twelfth weeks of streptomycin treatment. The present trend is toward the use of streptomycin in tuberculosis for periods of only sixty days or even forty-two days. Preliminary clinical trials suggest that therapeutic results are equal to those obtained with longer courses of treatment. The use of streptomycin in a daily dosage of 1 gm. for forty-two days makes for a very low incidence of toxic complications and offers the possibility that if relapse should occur a course of streptomycin can be repeated with good effect.

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The Diagnosis of Ruptured Fetal Membranes by Use of A Simplified Vaginal Smear Technique

Ann Gray Taylor, M.D. and Joan M. Roberts, M.D.

SINCE IN THE PRACTICE of obstetrics there are situations in which it is of importance to know whether rupture of the fetal membranes has occurred, a simple method of establishing this fact is of advantage. The method presented here is a practical one, requiring a minimum of equipment and of time. The interpretation of the stained smear, a somewhat formidable procedure usually, is in this study readily mastered by anyone able to use a microscope intelligently and familiar with the barest elements of cytology. This method is presented as a serviceable way for settling the question of whether the membranes have ruptured. Diagnosis by this method is also available to physicians who can take and fix the vaginal smears in the office or home and then submit them for microscopic examination.

The smears used in this study were taken at random from patients admitted to the obstetrical service of the Hospital of the Woman's Medical College of Pennsylvania. All of these patients were in or past their sixth calendar month of pregnancy. This study reflects an attempt to identify the fetal cells in the vaginal smear, and the correlation of the findings of the smear with the history of the patient. If the patient stated the membranes had ruptured, the history was considered positive. If the patient stated that there had been no leakage of fluid, the history was considered negative. If the patient was unable to state whether rupture had occurred, the history was considered questionable.

The equipment required for the taking and reading of these vaginal smears is not elaborate. A long-stemmed suction pipette, with a 20 or 30 cc. capacity rubber bulb is used to collect the specimen. The sterile pipette, which must be absolutely dry, is introduced 4 or 5 cm. into the vagina, and the secretions are then aspirated by releasing the bulb. The contents of the pipette are then ejected on to a clean, dry slide (thinness of the preparation is desirable) and fixed at once in a solution of equal parts ether and 95 percent alcohol. How long the smears remain in the fixative is not important: for purposes of later transportation or examination they may remain in the fixative for days or a week or two. If the smears are to be stained at once, they are left in the ether-alcohol solution one to two minutes, then removed and blotted dry. When they are thoroughly dry, they are stained by being well covered with "Clinichrome" stain for two minutes. This product is the Wyeth preparation of the Shorr single differential stain, which comes in dry form and can be made ready for use by any druggist. The stain is then blotted off, and the dry smear is immersed for one minute in 95 percent alcohol, followed at once by immersion in 70 percent alcohol. The smear is again blotted dry and then fixed in xylol for one minute. After being dried, the smear is ready for microscopic examination. In this study all smears were examined under low power with an ordinary Spencer microscope. The collection and preparation of the vaginal smear takes about six to eight minutes, and with a little experience the reading of the smear can be done in five to ten minutes.

This entire study was directed toward the finding of the fetal squamas in the vaginal smear. These disintegrating squamous cells from fetal epithelium are sufficiently characteristic to serve as diagnostic criteria of membrane rupture. The fetal cells have a tendency to form groups or sheets or clumps, and this feature is typical of their appearance in the smear. The borders of the fetal cells are discernible as such, but depending on the degree of disintegration the cell outlines may be wrinkled and crenated. The cell nuclei are necrotic, as is the cytoplasm, which is also pale and refractile. The fetal cells take a pale stain in comparison with the vaginal cells, and the squamas appear as buff colored, pale pink, pale blue, or grey cells rather than the brilliant green, blue, and rose tints of the vaginal cells. In the Shorr stain method the cells do not stain as

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distinctly as in the Papanicolaou method, and as a result the detail is far less clear. But for the purpose of recognizing fetal cells, the Shorr method is useful and timesaving. The abundant supply of mucus in the vaginal tract late in pregnancy makes a difference in the reaction and clarity of smears, though it does not obscure the fetal cells.

Control smears were made from amniotic fluid artificially released at the time of delivery, and from vernix obtained directly from the newly born infant.

This study included a total of 75 cases. The results are summarized in the table which follows:

History positive and smear positive in 32 cases
History negative and smear negative in 27 cases
History positive and smear negative in 4 cases
History negative and smear positive in 8 cases
History unknown and smear positive in 2 cases
History unknown and smear negative in 2 cases
History positive in 36 cases.....89% correlation
Smear positive in 32 cases.....11% error
History negative in 35 cases.....77% correlation
Smear negative in 27 cases.....23% error

The clinical application of this study is somewhat limited. However, when the question of the status of the fetal membranes does arise, it usually has a bearing on the subsequent management of the patient and as such is of practical importance. If, for example, a patient is admitted for ruptured membranes and a positive vaginal smear leaves no question about the diagnosis, such a patient may be given an induction, other circumstances permitting. If such a smear were negative after several examinations then expectant treatment, and not induction, would be in order. In some instances after a patient has been hospitalized many days because she was leaking amniotic fluid on admission, repeated negative vaginal smears will show the membranes to have sealed off secondarily. Such a patient may then be discharged with impunity. In a patient who is to be delivered by cesarean section, a knowledge of the status of the membranes is important if infection and contamination are to be prevented. The difference between a positive and a negative smear may mean the difference between a low cervical or extraperitoneal section and a classical section. A positive diagnosis of long-standing membrane rupture may also influence the patient's being delivered from above rather than from below.

These are some of the few but vital instances in which a knowledge of whether the fetal membranes have ruptured is of importance. It was with these instances in mind that this study was undertaken.

Summary

A simplified method of vaginal smear technique is used as a means of diagnosing ruptured fetal membranes.

The taking of the specimen and the preparation of the stained smear takes only six to eight minutes and does not require special training.

The diagnosis is made by identifying fetal squamas (stratified squamous epithelial cells in varying stages of disintegration) in the vaginal smears. These squamas are sufficiently characteristic to be recognized by an amateur cytologist after a short period of study.

The Shorr single differential stain is used. The fetal squamas are faintly staining squamous cells having a tendency to form groups or sheets and to cytoplasmic and nuclear degeneration. They stand out in contrast to the vaginal epithelial cells with which they are admixed. The presence of abundant fetal cells was considered positive evidence of rupture of the membranes.

The results of 75 random cases are presented. There was a 79 percent correlation between history and smear. Among the positive histories there was an 89 percent correlation and of the negative histories there was a 77 percent correlation.

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What Is Presymptomatic Cancer and How May It Be Diagnosed?

Catharine Macfarlane, M.D., F.A.C.S.

THE TERM "Presymptomatic Cancer" explains itself. It calls attention to the fact that cancer is insidious in onset and runs a symptomless course for an indefinite period of time. In the absence of serologic or other diagnostic tests, the only method now available for detecting presymptomatic cancer is the method of periodic physical examination.

From the standpoint of early diagnosis, cancers fall into two groups—accessible cancers and inaccessible cancers. Accessible cancers include cancers of the skin, buccal cavity, breast, uterus, and rectum. Inaccessible cancers include cancers of the brain, bones, digestive tract, respiratory tract, and urinary tract. Accessible cancers can be detected by the physician's trained eyes and trained fingers long before subjective symptoms attract the patient's attention.

Fortunately, accessible cancers occur more frequently than inaccessible cancers. Fortunately again, the vast majority of them can be detected by the general practitioner with the facilities available in his office. In the war against cancer, he is the first line of defense. If every general practitioner will take the trouble to make a complete physical examination of each of his patients at least once a year, many cancers will be discovered in the presymptomatic stage.

In addition to a careful inspection of the stripped patient with palpation of the breasts and abdomen, this examination should include a digital examination of the rectum after an enema, inspection of the genitalia, a bimanual pelvic examination and a careful inspection of the cervix "in a good light" through a vaginal speculum.

Periodic physical examinations are time consuming and rather monotonous. According to the statistics of the Donner Foundation Clinics in Philadelphia and of similar clinics in the State of Maryland, cancer was found in less than one percent of the examinees. Conditions requiring some form of medical or surgical treatment were found in about fifty percent of the examinees. In my own experience with periodic pelvic examinations, about half of the non-malignant lesions came under the rather controversial heading of "precancerous lesions."

It may be difficult to differentiate between presymptomatic cancer and lesions predisposing to cancer. Take the skin for example. A careful inspection of the stripped patient, front and back from head to foot, may reveal rough, scaly, pigmented warts and moles, senile keratoses, or the soft slate colored, slightly elevated lesions of melanoma. The same careful inspection may reveal persistent abrasions or ulcers under the bridge of the spectacles, at the sides of the nose, or behind the ears. The lesions may be benign or they may upon microscopic examination reveal an early cancerous change. Clearly they are no asset to the patient, who is far safer from the standpoint of cancer after they have been removed—excised, fulgurated, or irradiated.

Similarly in the buccal cavity a careful inspection of the lips, mouth, or tongue may reveal superficial ulcers or painless swellings that the patient had not noticed. This is the time for biopsy and treatment—surgery, radium, or x-ray, as indicated. The inspection may also reveal leukoplakia or factors of chronic irritation like jagged teeth, or badly fitting dental plates. These factors should be corrected before cancer develops.

In the breast, presymptomatic cancer takes the form of a painless swelling. This may be a circumscribed, freely movable nodule no larger than a pea. It may be an irregular thickening of breast tissue one or more centimeters in diameter. These painless swellings can be detected by gently pressing the breast against the ribs with the patient in the recumbent position. Or they may be detected by grasping the breast between two hands, one above and one below the breast, with the patient sitting up. Aside from their presence, they produce no symptoms. One out of every eight breast lumps is a cancer. From the standpoint of cancer con-

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trol, the lumps should be excised in the operating room where a frozen section can be made and radical mastectomy performed if indicated.

Inspection of the genitalia may reveal superficial ulcers or papillary outgrowths. Biopsy followed by excision, fulguration, or irradiation may be called for. Inspection may also reveal leukoplakic areas—precancerous lesions. Large doses of vitamin A may cause these lesions to disappear. If not, excision may be indicated.

One of the most rewarding fields of periodic examination consists in the careful inspection of the uterine cervix in a good light through a vaginal speculum. In the first examination of 1,319 presumably well, white women between thirty and eighty years of age, my colleagues and I at the Woman's Medical College found three early squamous cell cancers of the cervix. Two of these were quite unsuspected. They were discovered in the routine microscopic examination of excised areas of papillary erosion. The third squamous cell cancer was discovered by biopsy of tissue from a very large area of papillary erosion which looked suspicious. A polypoid adenocarcinoma was discovered on the eleventh semi-annual visit of one of these volunteers. This lady was symptom free.

Routine digital examination of the rectum after an enema may reveal at the depth of the examining finger a thickened rectal wall. If so, further investigation by proctoscopic examination or x-ray will be required. The digital examination may reveal a soft, polypoid structure, a rectal polyp, which is considered to be a predisposing factor in the development of cancer in this location. These polyps should be removed.

The discovery of inaccessible cancer in the presymptomatic stage is a difficult matter. Occasionally an early symptomless cancer of the lung may be discovered in the mass screening films now being made for tuberculosis.

For the detection of presymptomatic cancer of the stomach, the president of this Assembly, Dr. T. Gilson Engel, recommends that every annual physical check-up should include a gastric roentgenogram.

A suspicion of cancer of the urinary tract should be aroused by the repeated finding of red blood cells in the urine. Painless hematuria may be an indication of papillomata or of cancer in the urinary tract.

Largely though the efforts of the American Cancer Society the public has been educated to the point of asking for these examinations. People are more than willing to pay for them according to their means. It remains for the medical profession to do its part in meeting this legitimate demand. It remains for the medical schools of this country to train their students in the technique of periodic physical examination of presumably well persons with special reference to the detection of presymptomatic cancer.

Much is being said of late, about "The Future of the General Practitioner." Nowhere is he more needed than in the field of periodic physical examination. When every general practitioner's office functions as a cancer detection center, his income will be considerably augmented, and there will be fewer tragic cases of terminal cancer on his visiting list.

Vesical Apoplexy

Stanford W. Mulholland, M.D.

WHEN WE THINK of apoplexy there comes to mind the classical picture of a cerebral accident with sudden loss of consciousness and complete or partial loss of power of one side of the body. Seldom do we see blood vessels in other parts of the body rupturing with visible and diagnostic signs such as those producing cerebral symptoms.

The pathologic change in the rupture of a vessel related to the central nervous system is a flow of blood into the brain, spinal cord, or cerebrospinal fluid with resultant pressure on or anemia of the affected area. The most frequent site of cerebral hemorrhage is the internal capsule and the surrounding basal ganglia. The reason for this predilection lies in the fact that the arteries distributed to these parts, namely, the lenticulostriate and lenticulothalamic areas, are small and fragile and arise directly from large and strong vessels without the usual graduated transition to smaller size. They do not anastomose among themselves or with other vessels and have no collaterals. All these circumstances render them more apt to rupture, when under high pressure of hypertension, than the cortical vessels, for example, which branch a great deal. Urologists rarely see spontaneous rupture of blood vessels without ulceration or tumor.

The following case shows it can occur with rather alarming results:

Mrs. E. B., a white female, age 53, was admitted to the Woman's Medical College Hospital with a chief complaint of marked hematuria. Two days previously she had noted slight suprapubic distress accompanying an urgent desire to void. On urination a rather large amount of blood was noted for the first time. During that day rest in bed was advised and the bleeding seemed to lessen in amount. On the next day the bleeding returned rather profusely, with the passage of clots. Upon admission to the hospital she was voiding with difficulty because of the attempt to pass rather large clots. She had never had any previous bladder symptoms except occasional burning.

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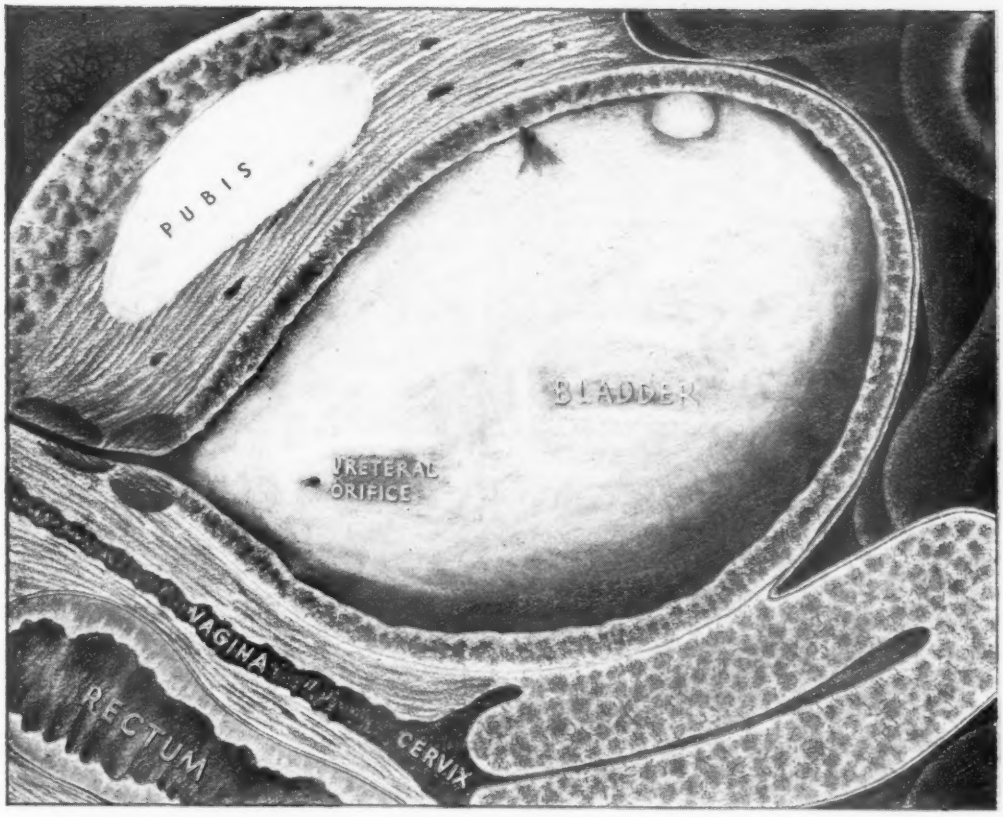
The past history revealed the fact that the patient had been known to have hypertension for ten years. The systolic readings had been reported as high as 240 mm. of mercury. Three weeks previous to admission she had a "weak spell" causing her to be dizzy and to fall. The blood pressure at that time was "200." An artificial menopause had been produced two years previously for menorrhagia. Radium was used within the uterine body. Her general health was much improved following this. The family history recorded that her mother had died at 62 years of age from heart and kidney disease. Father died of heart disease in his 82nd year. One sister living had cardiac disease.

Examination showed an obese, nervous, pale, rather apprehensive female. There was poor dental hygiene with pyorrhea II, graded on a basis of IV. The heart was enlarged. The apex was in the fifth interspace, 2 cm. to the left of the midclavicular line. There was a soft systolic murmur at the apex. The rate was regular at 120 beats per minute. The blood pressure was found to be 180 over 110. Red blood cells were 3,200,000 per cmm. and hemoglobin was 12.1 grams.

In spite of absolute rest in bed the bleeding continued for two more days. Four days after the onset of the bleeding, catheterized urine appeared like whole blood. The red blood cell count now was 1,800,000 per cmm. and hemoglobin was reported as 8.4 grams. The patient was very pale and apprehensive and manifested restlessness and air hunger.

Urologic consultation was requested, and immediate cystoscopic examination was advised. The bladder was found to be filled with clots which were evacuated with little difficulty. The entire bladder mucosa was reddened slightly. Two very small granulations were noted near the sphincter and close to the left ureteral meatus. After thorough inspection no definite bleeding point could be noted. The irrigating fluid returned clear. An indwelling catheter was placed in the bladder in order to put it at rest. The coagulants given previously were continued and transfusions were ordered.

As the blood pressure rose with repeated transfusions, it was evident that the bleeding continued from the bladder as noted in the drainage from the catheter. The hemoglobin was found



to be 38.4 percent, the red blood cells were 1,980,000 per cmm., and the blood pressure was 180 mm. systolic over 60 mm. diastolic.

Cystoscopy was repeated that evening and the bladder again evacuated of clots. After repeated search with the bladder distended and partially empty, a small blood vessel was noted spurting in the dome of the bladder. (Fig. 1) When the bladder was fully distended the bleeding lessened. When the patient was tremendously depleted of blood as at the first examination, this area had not been evident. The area was thoroughly electrocoagulated and an indwelling urethral catheter left in place. On the next day the blood pressure rose to 190 mm. systolic. There was no bleeding. Three days later another transfusion was given. The blood picture even then showed hemoglobin of only 50 percent, with 2,160,000 red blood cells per cmm. Ten days later the hemoglobin had risen to 67.3 percent. The blood count showed 3,000,000 red blood cells now present. The patient was dismissed from the hospital. She reports that she has been well for the past year.

Etiology

A degenerative state of the vascular walls is the chief underlying cause of non-traumatic cerebral hemorrhages. In such cases increased blood pressure will readily rupture the altered vessel wall. As to the causes of the alteration of the walls of the blood vessels, it occurs mostly in the degenerative period of life, taking place in most cases after forty years of age. Vascular changes are observed in arteriosclerosis, syphilis, and lead intoxication. Alcohol also predisposes to an atheromatous state of the blood vessels. Pernicious anemia, purpura, scurvy, chronic nephritis, and aortic insufficiency all lead to degenerative conditions of the blood vessels. Men are more liable to cerebral hemorrhage than women. Sometimes a hereditary disposition is observed; some families suffer for several generations from apoplexy. We must hold in mind that other organs than the central nervous system can be the site of severe apoplectic signs.

Sarcoidosis (Boeck)

Katheryn L. O'Connor, M.D.

SARCOIDOSIS HAS ATTRACTED the attention of various investigators since it was first described by Hutchinson in 1875 and recognized as a systemic disease by Schaumann in 1914. Many theories concerning the etiological agent have been advanced. Of these theories, that of a "benign type of tuberculosis" seems to be the one most discussed. Any organ of the body may be involved by the disease. The pathological picture of the lesion is the same regardless of the site of involvement. The typical lesion is a nodule composed of large, pale-staining, polygonal, epithelioid cells, about which there is no inflammatory zone. Little fibrosis is found between the nodules but in advanced cases the connective tissue may be hyalinized. Giant cells, when present, are not numerous and contain many nuclei and peculiar inclusion bodies.

The disease is characterized by a few constitutional symptoms in the presence of widespread involvement of one or more organs. The skin, lymph nodes, lungs, eyes, bones, liver, and spleen are the sites in which the disease is most commonly encountered. All of the lesions are characterized by latency and a tendency to slow regression. Fever may be present with uveoparotid involvement and in the acute phases of the disease. Changes in the results of the laboratory tests which may occur are: anemia and eosinophilia, frequently an increased sedimentation rate, elevated serum protein (due to hyperglobinemia), elevated serum alkaline phosphatase, and monocytosis during the acute stages.

Many therapeutic measures have been tried but their evaluation has been difficult because of the frequency of remissions in this disease. One of the latest drugs suggested is nitrogen mustard. (Snider, 1948). The response to nitrogen mustard in cases of Hodgkin's disease and the similarity of the lesions of Hodgkin's disease and sarcoidosis stimulated interest in the use of this drug for the latter malady.

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The following case report of Boeck's sarcoid is submitted because of its myocardial, as well as pulmonary involvement, and improvement (by EKG) of the heart after one course of nitrogen mustard.

CASE REPORT

A 16-year-old colored male was admitted to the Woman's Medical College Hospital July 20, 1948, complaining of marked respiratory distress. He had been in his usual state of good health until December, 1947, when he developed urticaria and swelling of his ankles. This condition lasted approximately one week and was followed by aching in his legs and left shoulder. Soon after this he developed dyspnea on exertion. His family physician made a provisional diagnosis of rheumatic fever and referred him to a hospital. He remained in that hospital from March until May of 1948 when his mother signed for his discharge. During this period all sputa were negative for tubercle bacilli and a tuberculin skin test was negative. A chest x-ray revealed a diffuse fine granular mottling throughout the entire right lung, confluent mottled density in the left base with a superimposed coarse mottled density in the right base. These findings remained unchanged while he was there. On occasions he had a temperature elevation up to 101° F. An electrocardiogram revealed diminished amplitude of T waves.

After leaving the hospital, the patient went to the Phipps Institute Sarcoid Clinic. On June 20, 1948, an axillary lymph node biopsy was performed at the Woman's Medical College Hospital. The pathological report was sarcoidosis. No tubercle

bacilli were found in the specimen. On July 13, 1948, he was vaccinated with BCG (0.1 cc. in the right deltoid). The following week he had repeated attacks of nausea and vomiting associated with periumbilical pain and dyspnea. His appetite had been poor for the two previous weeks and it continued to be so. He had lost approximately ten pounds of weight since the onset of his illness eight months previously. He developed severe headaches, dizziness, and marked weakness.

On his admission to the Woman's College Hospital on July 20, 1948, his temperature was 101.8, pulse 120, respirations 88, and blood pressure 80/60. He appeared very poorly nourished, markedly dyspneic, and acutely ill. His respirations were shallow and rapid and his nail beds and lips were markedly cyanotic. Adjacent to the lips was an irregular area of depigmentation approximately ¾ inch in diameter. No abnormal signs were found in the chest, and the liver and spleen were not palpable. There was no adenopathy and no swelling nor tenderness of the joints. On the day after admission his temperature and respirations returned to normal and remained there until his discharge, July 26, 1948, except for an elevation of temperature of two points on the fifth hospital day. The laboratory reports were as follows:

White blood cell count, 8,450; polynuclears, 61%; lymphocytes, 31%.

Gastric washings (3) showed no tubercle bacilli on smear or culture.

Intradermal tuberculin tests were negative (first and second strength PPD).

Serum calcium, 10 mg.%; phosphorus, 2.8 mg.%.

Total protein, 8.2 mg.%; albumin, 5.2 mg.%; globulin 3.0 mg.% A/G ratio, 1.7 mg.%.

X-ray films of the hands were negative. Those of the chest revealed fine mottling throughout all of the lung fields, with prominence in the hilar regions.

Ophthalmological examination showed "slight engorgement of the retinal veins."

EKG revealed left ventricular preponderance, low voltage of QRS in lead 1, diphasic QRS in lead 2, and inverted QRS in lead 3. The T waves were inverted in leads 2, 3, CF2, CF3, and CF4, with reduced voltage in the last two chest leads.

The patient was given 300,000 units of "Duracillin" daily and he improved and regained enough strength to be ambulatory. On July 28, 1948, he was discharged to return to the sarcoid clinic.

The patient was re-admitted on August 14, 1948, because of respiratory distress and a temperature elevation of 102°. Results of the physical examination on that date were essentially the same as on the previous admission except that a soft systolic non-transmitted murmur was heard over the precordium. The hemoglobin at that time was 14.2 gm. and the red blood count 4,000,000. The following additional studies were performed:

White blood cell count, 4,350; polynuclears, 20%; lymphocytes, 65%; monocytes, 5%; eosinophiles, 10%; segmented forms, 14%; stab forms, 6%.

Chest x-rays showed no changes from those on 8-21-48 and 9-3-48.

Ophthalmological examination was negative.

EKG on 8-24-48 revealed inverted and notched QRS in lead 3 and T waves low in lead 1, inverted 2 and 3, CF2-3 and diphasic in CF4.

On August 18 and again on August 21, the patient had a chill followed by a temperature elevation to 100° and 104°. On August 23 his temperature rose to 101°. He had no chill but had nausea and vomiting. During this period the white cell count ranged from 4,000 to 6,000. On August 24 and 25, he was given 5 mg. of nitrogen mustard (0.1 mg. per kilogram of body weight). The following day the white cell count fell to 2,600, so the injection was withheld until the next day when the count was 5,250. After the first injection of nitrogen mustard the patient had nausea and vomiting, but had none after the other two injections. On August 30, the white cell count was 2,200. Thereafter, it alternately rose and fell, with the lowest count 1,700 on September 3 and the highest 5,000 on September 14. On September 8, he became dyspneic and developed a cough productive of frothy white sputum. Physical examination of the chest was still negative. By September 14, the white cells had returned to 5,000 and he felt well enough to sit in a chair, so he was allowed to return home. On September 17, 1948, the patient had to be readmitted because of a chill, temperature elevation to 106°, cough, and respiratory distress. Palpable, firm, movable, non-tender nodes were found in the anterior and posterior cervical chains, axillae, and inguinal areas. A blowing apical systolic murmur was heard which disappeared in three days. Moist inspiratory rales were heard in the right apex and fine crackling rales in the left apex. Percussion note was resonant throughout, but chest x-ray showed no changes. Spleen and liver were not palpable. The tuberculin test was again negative but a crust was noted at the site of the old vaccination with BCG which had not been present on his previous admissions. Serum protein, globulin, albumin, calcium, phosphorus, and alkaline phosphatase levels were normal on this admission and his EKG showed improvement. The T wave changes described previously had disappeared.

At the present time, weakness is still a prominent symptom, his appetite is poor and he becomes very

dyspneic with the slightest exertion. However, he has no cough and has had no chill, elevated temperature, or attacks of nausea and vomiting since the one previously reported. It is planned to give him another course of nitrogen mustard.

SUMMARY

A case of sarcoidosis with pulmonary and myocardial involvement showed apparent improvement in electrocardiographic findings after a course of nitrogen mustard therapy.

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We are pleased to note that our desire for a Resident's Round Table as expressed in our November editorial has now become a reality with the contribution of a case report by the medical resident of the Woman's Medical College Hospital. This department is intended to be the property of our associate members, their medium for the publication of case reports and exchange of ideas. Our young members are also invited to call on the Round Table for answers to difficult problems which they meet in medical practice, whether scientific, administrative, or practical. Questions of general interest will be published—anonymously—with the answers.—*The Editor*

Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

EDITORIAL SECTION

A NOTABLE RECORD OF SERVICE

NINETY-NINE YEARS ago in an old-fashioned brick dwelling house at 627 Arch Street, Philadelphia, was founded the WOMAN'S MEDICAL COLLEGE OF PENNSYLVANIA, the first women's medical college in the world. Since that autumn of the year 1850, more than two thousand women physicians have graduated from that institution; one-sixth of all living American women physicians received their training there.

The Editors of the JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION have the honor of presenting this special number of the JOURNAL —The Woman's Medical College Number—in recognition of its significant contributions to the health and welfare not only of this nation but of the world, for the graduates of this pioneer institution are serving in many lands.

The Editors wish to express their gratitude to Dr. Carmen C. Thomas, Guest Editor of this number of the JOURNAL, who assembled these interesting scientific papers and historical articles:—we take great pleasure in introducing

DR. CARMEN C. THOMAS
Guest Editor

Dr. Carmen Thomas graduated from the University of Delaware in 1929 and in 1932 received her M.D. at the Woman's Medical College. She took a two-year internship at Philadelphia General Hospital, and then became an assistant chief resident there in 1934-35. She continued postgraduate work at the Medical School of the University of Pennsylvania and the Graduate School of Medicine as a Fellow in Dermatology and Syphilology and in 1940 received her D.Sc. (med.).

In 1941 she was appointed to the faculty of the Woman's Medical College to head the Department of Dermatology. Today, in addition to this post, and a lively private practice, Dr. Thomas has two other professional assignments: she is Associate in the University of Pennsylvania School of Medicine and in the Graduate School of Medicine in Dermatology and Syphilology, and is Chief in Dermatology at the Philadelphia General Hospital.

Besides having published many articles in her specialty, Dr. Thomas has served as guest editor for two Woman's Medical College issues of the JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION, and has been editor since 1947 of "Newsletter"—the Woman's Medical College Alumnae Association publication.

She is a member of Phi Kappa Phi, AMA, Sigma Xi, Alpha Omega Alpha, Society for Investigative Dermatology, AMWA, Past President of the Philadelphia Dermatological Society, Fellow of the College of Physicians of Philadelphia, and Fellow of the American Academy of Dermatology and Syphilology. In 1940, she was certified by the American Board of Dermatology and Syphilology. She has been President also (1945-1947) of the Woman's Medical College Alumnae Association.

Bernard Baruch has said, "Women are a natural in the field of medicine. Give them technique and training and you will furnish mankind with better doctors than ever before." Dr. Carmen Thomas, a young woman of personal charm and ability, singularly proves Mr. Baruch's statement and brings honor to her profession.

Cancer Detection and Trends in Medical Practice

THE TREND TOWARD placing the emphasis on the preventive rather than the curative aspects of medical practice had its inception several decades ago. Yet even now it is difficult to induce most individuals to give the same care to their bodily health as they give to their automobiles or their golf clubs.

Periodically special drives directed toward the early detection of special disease groups have been initiated, and bring large groups of individuals under rather specialized medical observation. We can cite the venereal disease detection work of the armed forces, and the blood-testing campaigns in blood donors or industry, mass chest x-ray surveys, and most recently the setting up of cancer detection centers.

Has medicine lived up to its obligation and done the best by such opportunities? In the course of the screening examinations and diagnostic procedures necessary to detect or exclude the presence of cancer, for example, many more medical or surgically remediable defects will be found than cancer. (In the Donner Clinics of Philadelphia, for every 100 apparently well individuals examined, one is found to have an unsuspected cancer, and approximately 50 have remediable medical or surgical defects.) Is the time, effort and expense expended in uncovering this one per cent of unsuspected cancer worth it, if the other uncovered abnormalities are neglected?

The expansion of the specialty aspects of medical practice in recent years, has tended to make doctor as well as patient think of the body as so many geographically separate systems, all strictly segregated and watched over jealously by superspecialists, who often overlook the forest for the trees.

That the advice even of a too specialized consultant group may often work to the disadvantage of the patient is brought out in the paper of Dr. Katharine Boucot in this issue, citing an instance where too much delay in attempting to make a definite diagnosis of tuberculosis deprived the patient of surgery which might have removed his tumor in time. This same tendency has been described by Dr. Hayes Martin and others in the event of unsuspected cancer and co-existing syphilis, where a prolonged course of antiluetic therapy is undertaken, meanwhile allowing the cancer to progress to an advanced state.

This trend is being effectively counteracted by the setting up of cancer teaching and control programs in the medical schools of this country made possible by the liberal federal grants for this purpose. The patient is examined by a group composed of medical and surgical specialists who have the advice of the radiologist and the pathologist immediately at hand, so that a discussion of the patient's problem as a group with group recommendations for his treatment can be made. The broadening effect of such an exchange of views on the participating physicians is not the least important result of these conferences. The expansion of such group meetings to allow the attendance of physicians in practice as well as medical students should prove of inestimable benefit. Ultimately it may be found feasible to set up such teaching centers in communities which do not have the benefit of medical schools in their midst. If no other benefit ensues that the reintegrating of medical specialties so that the patient is again considered as a whole, a great deal of good will have been accomplished.

CARMEN C. THOMAS, M.D.

Ann Preston: *Physician*

Margaret Castex Sturgis, M.D.

TODAY WHEN HORIZONS seem limitless and practically every frontier for women in medicine has vanished we must not lose sight of the women who made this possible. To Elizabeth Blackwell belongs the honor of taking the initiatory step. To Ann Preston, in the words of Dr. Eliza E. Judson, spoken in 1873, belongs the honor of having "done more than any other one person for the advancement of the medical education of women."[2]

In 1869, in "Eminent Women of the Age,"[1] Ann Preston is listed as one of the five outstanding women physicians of that day, and the volume contains a very good biographical sketch. The article written during her lifetime reflects her very modest and retiring character, with these words: "Indeed the few facts we are allowed to use are given us for their bearings upon the cause rather than for personal representation. Identified with the College and the Hospital, she prefers to be known chiefly through them and to have her reputation merged in whatever good they may accomplish."

In reading over the collected data at the Woman's Medical College of Pennsylvania I found that personal letters, lectures, addresses[6], a book of poems, a letter to the Pennsylvania Hospital requesting the privilege to enter the hospital for purposes of observation, replies to the Philadelphia County Medical Society about their refusal to recognize women physicians, all paint a vivid picture of that dynamic, determined, able, though physically frail little woman. Later, the "In Memoriam" address by Dr. Judson[2] and subsequent personal recollections as voiced by her students and fellow alumnae attest further to her personality, her ability, and her achievements. "To the cause of women, her work and example are invaluable. Her personal character was so high, her ability so great, her judgment so accurate, her nature so truly feminine, her success as a physician so universally acknowledged, that her life was an unanswerable argument against those who would exclude women from the medical profession."

Ann Preston was born in December 1813, in West Grove, Chester County, Pennsylvania, the daughter of Amos and Margaret Preston. She was born on the old homestead of her grandfather, where her own father had been born and where

Portrait of Ann Preston, M.D.
1813-1872 (W. M. C. 1852)
Miss Carol H. Beck, Artist
(Painted in 1900 from photograph taken about 1870)

he lived and died. In this home Ann spent the first thirty-six years of her life, a life which at that time promised to be very uneventful.

Amos Preston was a member and a minister of the Society of Friends. He was a man of rare ability and was ever mindful of the wants and interests of others. He was held in high esteem and much beloved and trusted by his friends and associates. Margaret Preston has been spoken of as "intellectual, refined, and delicately appreciative of the beautiful in nature and art." She is said to have had great strength of will but a "sensitive nervous organization." The combined traits of both father and mother appear inherent in Ann Preston.

With the death in infancy of a sister and with the delicate health of her mother, Ann's early life was one filled with great responsibility. The six boys of the family gave to it a picture of restless activity and excitement. Her warm, loving, and social nature did not suffer from the intimate association with these free young lives around her.

It was the inspiration from childhood days that found expression in the stories and poems which she wrote later in her life. Her book, "Cousin Ann's Stories,"[5] written chiefly in verse, was published in 1849.

Her early education was obtained in a school near her home in the country, with one year away at a boarding school in West Chester when she was eighteen. Letters written at the time to a friend, Sarah Coates, portray a normal school girl with the youthful interest in the social happenings characteristic of those days. A letter written a year later stated that she missed the school life but that she was teaching a small private school in her home. The neighborhood of her home, however, was one of culture and a center of learning. She had free access to a most valuable library, and she became a member of the Lyceum and Literary Association. These did much to cultivate her taste for literature. Nevertheless she never ceased to regret that she lacked the rigid mental discipline which comes from an early classical education.

Ann Preston was a birthright member of the Society of Friends and from this background of stern liberality she emerged a young woman ardently interested in the various reform movements of her day. She possessed an innately sympathetic, sensitive nature and a very inquiring and studious mind. It is not surprising then that Ann Preston, with her intense feeling, her great love for liberty and justice, allied herself with the anti-slavery movement and became a staunch abolitionist. Prior to the organization in 1833 of the American Anti-Slavery Society she was a member of a local group founded in the neighborhood. It was in this organization and in the Lyceum that she became known as a forcible writer because it devolved on her to write regrets and petitions, and even write and give addresses.

Ann Preston's insatiable drive for a fuller and broader life did not find its opportunity until she was thirty-seven years of age. It was at that time, in 1850, that she entered the first class of the first College regularly established for the granting of the medical degree to women. In 1853 she was one of the eight members of the first graduating class of the Woman's (then Female) Medical College of Pennsylvania.

With the doors of all hospitals closed against them, these early graduates had great difficulty in obtaining clinical advantages. Some went to other cities and some sought opportunity abroad. Dr. Preston remained in attendance at the College for the following term, and that spring was offered the chair of physiology and hygiene. So at the age of thirty-nine she entered upon what she termed the great work of her life, the furthering of the education of women in medicine. As a teacher, she has been described as possessing rare natural talent. Her teaching, however, was supplemented by lectures in hygiene. Through these she became a popular public speaker and in this way, from a wide circle of acquaintances, developed a very good office practice. Her delicate health forbade her doing obstetrics and making night calls.

During all the while Ann Preston was ever increasingly aware of the great need for the bedside instruction for the women students of medicine. She conceived the one and only means of fulfillment: to establish a hospital for women and children which would be under the management of women and which would furnish clinical opportunities for instruction of the women students of the Woman's Medical College of Pennsylvania. There was no alternative if the College was to go on; a hospital—"one of the objects should be the education of women as physicians"—must be founded. In speaking of it, Ann Preston said: "I went to every one I thought would give me either money or influence." And by so securing the assistance of the corporators of the College, the faculty, and friends, a charter was obtained in 1861 for the establishment of the Woman's Hospital of Philadelphia. Dr. Preston was made a member of the Board of Managers, the corresponding secretary, and a member of the attending medical staff.

The financial depression concurrent with the Civil War, then raging, was felt by the College as well as the scarcity of students, so the session of 1861-62 was omitted. In the re-opening of the College in the fall of 1862 the hospital, which was well under way and in successful operation, aided much in furthering the usefulness of the teaching organization. In fact it gave the College the needed impetus.

Just at this time, following a long illness of her mother, Ann Preston had a painful and prolonged attack of what was then called acute articular rheumatism. Her convalescence was slow and protracted; however, the following fall she was able to resume her work at the College. It has been said that the next ten years of her life were her most fruitful ones.

In 1866 Ann Preston was made dean of the faculty of the Woman's Medical College, and the following year was made a member of the Board of Corporators of the College. It was that year

that she wrote her memorable reply[7] to the resolutions adopted by the Philadelphia County Medical Society which refused to permit its members to consult with women physicians and forbade them to hold professorships in the College or to consult with its professors. It has been said that "Dr. Preston's logic was so convincing, her style so lucid, her appeal for wider opportunities for her sex so eloquent, that in the many years that have passed since it was written, this document has lost nothing in dignity and force."

Within the next few years Dr. Preston saw many changes. Hospital doors slowly began to open to women medical students for instruction. The admission of women students to the clinics of several of the leading hospitals of Philadelphia was indeed a great era in the College history. It was Dr. Preston who was present with her students at the first clinic at the Pennsylvania Hospital in 1869. It was a very memorable occasion because the women students were insulted by the young male students present and it was frail little Ann Preston who marched in the street with her small group of students because the sidewalks were completely occupied by the "sterner sex."[3]

As a practitioner of medicine Dr. Preston has been described as having been most successful and as having had a large following of loyal and devoted patients. She was equally loved and trusted by them. It was said too that "through her practice a goodly competence was attained."

Dr. Preston loved her childhood home and family but she desired greatly a home of her own. Though never married she did acquire a home and a family circle in her late years. Her singleness of purpose and her constant striving for the right were qualities which made her a leader among her co-workers. Dr. Newlin Pierce said of her many years after her death, "That frail and friendly form, that Quaker prophet and poet, with her quiet spirit, was a force, a factor, which carried an influence worth a whole regiment of men."[4]

During the spring of 1871 she was again afflicted with acute articular rheumatism, possibly what we call today acute rheumatic fever. From this attack her recovery was never complete although she was back at the College for the fall term. This time she was exhausted by the work and it was soon evident that her health was rapidly failing. She did prepare the annual announcement for the College session of 1872-73, which was her last work.

Dr. Ann Preston died at the age of fifty-nine years on April 18, 1872. So ended twenty-two years as a student of medicine, teacher, physician, corporator, hospital founder and manager. These last years of her short span of life were so intimately a part of the history of the Woman's Medical College that to know her one must know the College. And this is as she would wish it to be. The furtherance of the medical education of women was the cause to which she had dedicated her life with a true consecration. It was said that she made the "interests of the College her interest, its honor her honor, shrank not from its obloquy, shared its pecuniary embarrassments, labored to increase its advantages and elevate its standard of scholarship."

As a last fitting end to a beautiful life, she left a will devising much of her small estate to further after her death the aims of her life.[5] Her medical equipment in instruments and books was left to the College to be used by women students of medicine; the interest on $4,000 was left to the College to be used annually to assist in the medical education of "one good capable woman;" and $1,000 was left to increase the endowment fund of the Woman's Hospital of Philadelphia.

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Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

INTERNATIONAL SECTION

THE CAMPAIGN AGAINST TUBERCULOSIS OF THE WORLD HEALTH ORGANIZATION

THE LARGEST SINGLE health campaign ever undertaken is now in progress under the technical direction of the World Health Organization. Co-operating in the program are the International Children's Emergency Fund, the Scandinavian Red Cross societies, and the local governments. For the first time in history, tuberculosis, the white plague, is being combatted on an international scale by the co-ordinated efforts of doctors, nurses, and health workers, backed by superior laboratory and other technical work and financed by a budget of almost 5 million dollars.

This concerted drive against TB is in force now in Czechoslovakia, Yugoslavia, Poland, Hungary, Finland, and other devastated countries of Europe, and is about to be extended into Germany. It is in operation in Asia, where China and India are participating, and the plan will soon be extended to North Africa.

The campaign is a preventive one. A principal aim is to make children safe from tuberculosis by vaccinating them with BCG.

BCG (which stands for Bacillus Calmette Guérin) is an anti-tuberculosis vaccine which was first developed nearly thirty years ago by the two French scientists for whom it is named: Dr. Albert Calmette and Professor A. Guérin. Since then it has been tested and applied on an ever increasing scale in many countries with such convincing success that today it is almost everywhere considered the best single immunizing agent against TB. Its use is confined, however, to those not yet infected.

Greatest impetus to the development of BCG as a potent weapon in the control of tuberculosis was given by the occupied Scandinavian countries during the war. Health authorities in Denmark and Norway, faced with the many diseases which threatened a population weakened by war and its accompanying malnutrition, overcrowding, destruction of sanitary facilities, and general economic depression, seized on BCG as the weapon most suited to save their children from the major threat of tuberculosis. Laboratories in Copenhagen and Oslo began preparing BCG under dangerous war conditions, and launched their campaign in secret to vaccinate the most exposed groups of the population. Success rewarded their efforts; sickness and death rates from tuberculosis dropped 60 to 70 percent among the vaccinated population!

At the end of the war, statistical reports from devastated countries where no such preventive measures had been taken showed that TB had reached almost epidemic proportions and that in many parts of the world tuberculosis was the chief cause of death among children and young adults. In the face of these disastrous conditions, the World Health Organization went into action. Its biological experts began work on standardizing the BCG vaccine and setting up international procedures for its use. At the same time other WHO specialists were developing uniform procedures for tuberculin testing.

The UN International Children's Emergency Fund participated in the campaign by allocating 2 million dollars for Europe. The Danish Government is contributing about $420,000, the Norwegian Help for Europe about $300,000, and the Swedish Red Cross about $110,000. The Danish Red Cross and its Scandinavian associates furnished medical and nursing personnel possessing the technical skill and experience needed for the program. Thus, what is known as the International Tuberculosis Campaign was born.

This is now operating to give 50 million children in Europe alone the tuberculin test. About 15 million of these will be given immunizing vaccine.

The very high infection rate among European children is evidence of the ravages caused by war among the most vulnerable age group of the population. Europe, moreover, is not the only continent affected. China, insofar as statistics have

been collected, shows even higher TB sickness and death rates. In Shanghai, for example, an analysis of sputum collected in streets and other public places showed that 16 percent contained active bacilli. In several large Chinese cities, WHO teams are at work vaccinating the still uninfected groups while native personnel is being trained to care for those suffering from the disease.

In India last month, WHO installed the first BCG laboratory and launched the first BCG vaccination campaign. The campaign will be extended in November to the Dominion of Ceylon by WHO demonstration teams.

As the world-wide anti-tuberculosis campaign gains ground, the World Health Organization is at work developing further plans—not only for the prevention of this disease but for its treatment and cure, to the end that tuberculosis, the "white plague" of history, may some day be vanquished as a menace to mankind.

THE MALARIA PROGRAM OF THE WORLD HEALTH ORGANIZATION

A GOOD EXAMPLE of the manner in which the World Health Organization is spearheading the fight against disease is the malaria program. Its objective: to assist governments in improving and developing effective national and local control programs based on modern scientific methods; to promote the widest and most effective use of new methods of malaria control; to develop and promote measures to protect countries against the introduction of foreign anophelines (malaria-carrying mosquitoes) and to develop uniform international epidemiological procedures and nomenclature in malariology, including relevant insect names.

As a first step toward achieving this objective, WHO's Interim Commission appointed an expert committee on malaria which surveyed current world knowledge of the field and proposed steps to be taken by WHO. In view of the findings, the World Health Assembly instructed the Executive Board to consider the following:

That governments, where malaria is a problem, take—subject to the conditions in their countries—preventive, curative, legislative, social, and other measures necessary for malaria control, particular attention being paid to:

(i) Systematic registration, where practicable, of malaria cases.

(ii) An appropriate organization for detecting new cases.

(iii) The importance of adequate treatment.

(iv) Measures, so far as practicable, for tracing the movements of malaria cases and carriers to prevent spreading of the disease.

(v) The importance of extensive use of insecticides.

(vi) The importance of making therapeutic and prophylactic treatment available to all who require it, regardless of ability to pay.

(vii) The improvement of methods of irrigation, cultivation, and animal husbandry (including zooprophylaxis wherever this is advantageous) so that they will tend to reduce rather than intensify malaria prevalence.

(viii) The careful planning of housing programs, taking into consideration the relevant phases of malaria surveys.

(ix) The active support of scientific research with a view to improving therapy and malaria prophylaxis.

To put malaria control on a global plane WHO will give expert advice to governments on the control of malaria and on educating the public. It will make available fellowships and visiting experts, demonstration teams, and technicians. It will stimulate the production of insecticides and therapeutic agents on an international scale and improve their distribution. It will collect and distribute technical information. It will develop international regulations. And WHO will cooperate with other organizations concerned with malaria.

Current Publications of Women in Medicine

Wittman, Phyllis, and Sheldon, W.: A proposed classification of psychotic behavior reactions. Am. J. Psychiat. *105:* 124-128, Aug. 1948.

Authors save outlined a tentative check list of psychotic behavior traits, based on 3 psychotic behavior components: 1. affective exaggeration, 2. paranoid projection, and 3. schizophrenic withdrawal.

Campbell, Kate: Intracranial disorders of the newborn associated with birth. M. J. Australia *2:* 57-63, July 17, 1948.

Author discusses intracranial disorders due to hemorrhage, anoxemia, and fracture of skull and the causes of these. The importance of oxygen lack to the fetus as a cause of death and of symptoms in later life is stressed. Efforts should be directed to the cutting down of fetal anoxemia and prevention and early adequate treatment of intracranial hemorrhage.

Stable, G., and **Philpott, Iris G.:** An epidemic of gastro-enteritis in infants with special reference to treatment. M. J. Australia *2:* 63-69, July 17, 1948.

(From Brisbane Children's Hospital.)

During 1947 a severe epidemic of gastro-enteritis in the city and suburbs of Brisbane necessitated hospitalization of 384 infants. About half of the cases and most of the deaths were caused by a group C Salmonella identified as Salmonella bovis morbificans. At the height of the epidemic the mortality rate was 40 per cent. This was lowered and maintained between 2 and 3 per cent by successful treatment. Most cases occurred among artificially fed infants. Most effective therapeutic diets were a sequence of a 5 per cent solution of glucose or sucrose in water, whey, whey-modified milk, modified milk. In all severe cases intravenous treatment with half-strength physiological saline solution and 5 per cent glucose solution was needed. Deaths occurred from protein starvation and toxic spoiling of the liver until amino acids (casein hydrolysate) were given as well. Serum therapy was of little value. Streptomycin, in doses of 25 to 50 milligrams given intramuscularly every three hours was most effective in the toxic salmonellosis stages but had no effect on the enterocolitis.

Cotton, Cornelia M., and Swope, R. E.: Brucella-chemotherapy. 1. Studies of the effect of para-aminobenzoic acid on brucella in vitro. 2. Para-aminobenzoic acid in the treatment of experimental brucellosis in guinea pigs. Am. J. Vet. Research *9:* 164-168; 169-172, April 1948.

(From Maryland State Board of Agriculture, University of Maryland, College Park.)

In the first study the bactericidal effect of para-aminobenzoic acid on brucella in vitro was demonstrated. In the second study, guinea pigs heavily inoculated with a virulent bovine strain of B. abortus were treated with the sodium salt of para-aminobenzoic acid. A 5 per cent solution, administered subcutaneously, in 5 cc. amounts every 4 hours for 21 days, appeared to produce sterilization in 100 per cent of animals when treatment was begun 3 days after infective organisms were injected. Where treatment was delayed for two weeks after infection 80 per cent of animals were negative to cultural examination of the spleen, liver, kidney, heart, lungs, and reproductive organs.

Hardy, Harriet L.: Delayed chemical pneumonitis in workers exposed to beryllium compounds. Am. Rev. Tuberc. *57:* 547-556, June 1948.

(From Division of Occupational Hygiene, Massachusetts Department of Labor and Industries, Boston, Massachusetts.)

Pertinent material from the clinical records of 36 workers exposed to beryllium compounds is presented in an attempt to bring out the epidemiology and chief clinical features of an apparently recently recognized occupational illness designated as delayed chemical pneumonitis. The distinctive clinical features are: a usual delay in onset, dramatic weight loss and dyspnea and long duration of illness. There is usually a history of remote exposure to beryllium compounds. In each case it is necessary to exclude pulmonary tuberculosis, silicosis, or sarcoidosis as a cause of the illness. The etiology and pathogenesis of delayed chemical pneumonitis have not been clearly established but experience with occupational illness and experimental studies give evidence which tends to incriminate beryllium compounds.

Frantz, Virginia Kneeland: Experimental studies of alginates as hemostatics. Ann. Surg. *127:* 1165-1172, June 1948.

(From Department of Surgery and the Surgical Pathology Laboratory, College of Physicians and Surgeons, Columbia University, New York.)

Local tissue reaction to various spun and woven preparations of alginic acid and its derivatives were studied in a series of rat tests. The immediate hemostatic effect of alginic acid preparations was contrasted with controls of oxidized gauze in the spleen and liver of dogs. It was concluded that the advantage to be gained by sterilization in the autoclave was outweighed by the less effective hemostatic action and by the toxic properties of the alginates, and that further experimental study was not warranted. It was not thought safe to propose these new preparations for trial in clinical surgery.

Padgett, E. C., Robinson, D. W., and **Stephenson, Kathryn L.:** Ankylosis of the temporomandibular joint, Surgery *24:* 426-437, Aug. 1948.

(From the Department of Plastic Surgery of the University of Kansas Medical School.)

Because temporomandibular ankylosis is relatively uncommon, twenty-two cases were analyzed with respect to etiology, pathology, and treatment. Of these 16 were cases of true ankyloses, 5 of false due to extra-articular fibrosis, and one was caused by developmental abnormality of the jaw. True bony ankylosis is most frequently caused by infection of trauma; pseudo-ankylosis results from soft tissue fibrosis chiefly following burns, wounds, infection, or irradiation. Pathology found at the time of surgery in early cases of true ankylosis is most often an intra-articular fibrosis but in more advanced stages a massive bony hypertrophy is present. Diagnosis in early and late cases is discussed and treatment is described.

McArthur, Janet W., Rawson, R. W., Fluharty, R. G., Means, J. H.: The urinary excretion of radioactive iodine as an aid in the diagnosis of hyperthyroidism, Ann. Int. Med. *29:* 229-237, Aug. 1948.

(From the Thyroid Clinic of the Massachusetts General Hospital and the Department of Medicine, Harvard Medical School, and the Radioactivity Center of the Department of Physics of the Massaehusetts Institute of Technology.)

The mean urinary excretion of radioactive iodine by 22 thyrotoxic patients was 25 per cent (range 7 to 45 per cent). In 30 non-thyrotoxic patients it was 60 per cent (range 23 to 98 per cent). There is considerable overlapping in the radioactive iodine excretion between thyrotoxic and non-thyrotoxic individuals in the range 20 to 40 per cent. The finding of a low urinary excretion of radioactive iodine aided in establishing the diagnosis of Graves' disease in clinically equivocal cases while the finding of a high urinary excretion aided in excluding it. Search for external gamma radiation with the Geiger-Muller counter following the administration of a tracer dose of radioactive iodine enables the location of thyroid tissue to be established when doubt exists.

Heindl, Irena A., Anderson, B. G., and Friedlander, R. D.: Acute idiopathic hypoprothrombinemia; response to massive doses of vitamin K. Ann. Int. Med. *29:* 347-356, Aug. 1948.

(From Franklin Hospital, San Francisco.)

A case of so-called idiopathic hypoprothrombinemia successfully treated with large doses of vitamin K is described. This case is compared with previously reported cases. The influence of salicylates on prothrombin time is discussed.

Harris, Ruth C., McDermott, T. F., and Montreuil, F. L.: The treatment of tetanus. Report of two cases with critical comment on new therapeutic resources, Pediatrics *2:* 175-185, August 1948.

(From the Departments of Pediatrics, Anesthesiology, and Otolaryngology, Columbia University College of Physicians and Surgeons, and the Babies Hospital, New York.)

The cases of two patients with tetanus, one severely and the other moderately ill, are presented in detail. Both were treated with large doses of antitoxin, curare, penicillin and sulfadiazine, tracheotomy, and sedation. Both recovered.

Few reports of the use of tracheotomy in this disease have appeared in the literature. It was felt that it greatly benefited these patients in whom it was used prophylactically to prevent fatal laryngospasm, and therapeutically to provide an adequate airway and exit for accumulated thick gelatinous secretions. Adequate regular aspiration of the tracheotomy tubes was found to be mandatory while the patients were severely ill and while deep sedation was required. It was found that positive pressure oxygen could be administered through the tracheotomy tube for respiratory arrest while the patient was under curare and pentothal sedation. A simple apparatus for this purpose is described.

Clay, Augusta Stuart: Guidance in maternal and infant care two months before and after the birth of the first-born. Pediatrics *2:* 200-206, August 1948.

This study was made in the belief that family living and growth can be healthier if parents understand how mother and baby develop and what they need. Eleven mothers (ten were registered in the prenatal clinics of the Grace-New Haven Community Hospital, the eleventh had a private doctor) were visited weekly for two months before and after the birth of their firstborn to discover what guidance they wanted, what was offered, and what additional guidance was needed. The reactions of the mothers to the various situations and their suggestions as to what additional guidance was needed are recorded.

Frazer, Mary Margaret: The Detroit Women's Cancer Detection Center and its relation to the general practitioner. M. Woman's J. *55:* 26-30, August 1948.

The history, aims, services of the center are described by the Medical Director.

De Hoogh, Esperanza Oteo: Social work in the campaign against leprosy in Mexico. M. Woman's J. *55:* 15-25, 30, August 1948.

In the fight against leprosy it is necessary to consider the patient individually, psychologically, socially, and economically. The methods used in Mexico are described.

Lombard, H. L., Middleton, M., Warren, S., and **Gates, Olive:** Use of the vaginal smear as a screening test, New England J. Med. *239:* 317-321, August 26, 1948.

(From Tumor Diagnosis Service, Massachusetts Department of Public Health.)

The present findings indicate that by the cytologic test for cancer it may be possible to find one case of uterine cancer among 200 to 500 women free from symptoms. The final evaluation of the technique as a screening test cannot be made until the results of the follow-up study are known three years hence.

Kesten, Beatrice Maher: Treatment of allergic and other dermatoses with pyribenzamine hydrochloride, Ann. Allergy *6:* 408-414, 438, July-August 1948.

(From Department of Dermatology, Columbia Presbyterian Medical Center, New York.)

This study, begun in November 1945, covers 280 patients who were observed long enough to determine the value of pyribenzamine. The standard oral dose was 50 mg. after meals and 100 mg. at bedtime for a minimum of one week unless symptoms disappeared or side effects developed. Pyribenzamine was beneficial in the treatment of 191 patients (approx. 68%) with allergic and other itching dermatoses. It gave prompt and complete relief to patients with serum sickness and to many with urticaria due to penicillin. Its continued use effectively controlled physical allergies and dermographism. It completely relieved or controlled the symptoms in 65% of patients with urticaria and depressed itching, in 60% with allergic eczema, in 40% with dermatitis venenata and in 75% with pruritus. Its antipruritic and sedative effect as an orally administered drug makes pyribenzamine a welcome adjuvant in the treatment of a variety of dermatoses accompanied by severe itching. It was discontinued in about 13% of patients because of side effects.

Henle, Gertrude, Henle, W., **Wendell, Katherine K.,** and Rosenberg, P.: Isolation of mumps virus from human beings with induced apparent or inapparent infections. J. Exper. Med. *88:* 223-232, Aug. 1948.

(From the Children's Hospital of Philadelphia [Department of Pediatrics, School of Medicine, University of Pennsylvania] Philadelphia.)

Exposure of 15 children to mumps virus of fifth amniotic passage in chick embryos led to involvement of the salivary glands in six, orchitis in the absence

of other manifestations of mumps in one, and to no signs of illness in eight. Attempts to isolate virus from the saliva of these individuals gave the following results: 1. All patients with involvement of salivary glands excreted virus beginning on the 11th to 15th day after exposure, 2 to 6 days prior to onset of clinical signs and extending up to 4th day of illness; 2. The patient with primary orchitis excreted virus for 2 days, beginning on the 15th day after exposure and 10 days prior to his illness; 3. Six of the 8 children classified as having inapparent infections because of their serologic response in the absence of clinical signs of illness began to excrete virus on the 15th to 16th day after exposure for from 1 to 9 or more days. The epidemiologic significance of these data is discussed.

Ruskin, S. L., Merrill, Alice T., and Ruskin, O.: The influence of ascorbic acid, sodium ascorbate, calcium ascorbate, and orange juice on dental enamel. Am. J. Digest. Dis. *15:* 302-303, Sept. 1948.

Five groups of teeth were studied, each group having one tooth containing a beginning cavitation. These were placed in beakers containing the solutions to be studied. One group was placed in a beaker of water. From the experiments it appeared that the normal drinking of orange juice had no effect on the enamel of the teeth except where cavitation had already been produced. This makes it extremely important to fill cavities, especially in children. Ascorbic acid should also be replaced by a neutral salt such as sodium or calcium both of which fail to show any involvement of the dental enamel.

Tamagna, Irene G., and Poindexter, C. A.: A comparative evaluation of tetraethylammonium chloride and sodium amytal in patients with hypertensive cardiovascular disease. Am. J. M. Sc. *215:* 651-654, June 1948.

(From the Division of Cardiology, Department of Medicine, New York Post-Graduate Medical School and Hospital.)

The effect of these drugs was studied on 68 hypertensive patients and a marked parallelism in the drop of blood pressure was observed in both tests.

Ruys, A. Charlotte: Bacteriological and epidemiological data on typhoid fever in Amsterdam. Am. J. Pub. Health *38:* 1219-1224, Sept. 1948.

(From the Municipal Public Health Laboratories, Amsterdam, Holland.)

During and after the war three large epidemics of typhoid were observed, one caused by smoked eels, one by salt herrings, and another by milk contaminated by a chronic carrier in a dairy plant. By means of highly selective media several temporary carriers of typhoid bacilli were found. These were selenite enrichment fluid and the Wilson-Blair, S. S. desoxycholate-citrate media, and others. It is recommended that a series of highly selective media should be used for the isolation of typhoid bacilli, such as the ones mentioned.

Donnelly, Grace C., and Bauld, W. A. G.: Aspects in the treatment of vulvar and cervical carcinoma. Am. J. Obst. & Gynec. *56:* 494-501, Sept. 1948.

(From Radium Clinic, Royal Victoria Montreal Maternity Hospital, and Department of Obstetrics and Gynecology, McGill University.)

Three groups of pelvic malignancies treated at the Clinic from 1926-1945 were selected for closer study: carcinoma of the vulva, carcinoma occurring in the cervical stump, and selected cases of carcinoma of the cervix treated by radiation and surgery. These are considered from the standpoint of age, incidence, location, symptoms, appearance of gross lesion, metastases, methods of treatment, and years of survival.

Potter, Edith L., and Dieckmann, W. J.: Fetal and infant mortality for the Chicago Lying-in Hospital: 1941 to 1946. Am. J. Obst. & Gynec. *56:* 593-597, Sept. 1948.

(From Department of Obstetrics and Gynecology, University of Chicago, and Chicago Lying-in Hospital.)

The total mortality for 17,500 infants weighing over 1000 gm. delivered between July 1, 1941, and July 1, 1946, is 25 per 1000, and is equally divided between stillbirths and neonatal deaths. For 1015 infants born alive weighing less than 2500 gm., the mortality was 13.1%; for 16,421 born alive weighing more than 2500 gm., the mortality was 0.5%. The causes of death for the 440 infants who were stillborn or who died in the first 10 days of life, in order of frequency are: anoxia, malformations, intrauterine deaths of unknown origin, prematurity, erythroblastosis fetalis, pneumonia, birth trauma, miscellaneous causes, and syphilis.

Weil, Inga F., and Lerner, H. H.: A case of long standing sickle cell anemia with marked bone changes. Am. J. Roentgenol. *60:* 251-255, Aug. 1948.

(From Department of Radiology, University of Utah School of Medicine, Salt Lake County General Hospital, Salt Lake City.)

A case is reported showing unusual roentgen changes in the skull, tubular and flat bones.

Bloomberg, W., Silverman, S., Levingston, Anne G., and Murphy, W. F.: An intensive neuropsychiatric treatment program in a veterans hospital. Am. J. Psychiat. *105:* 204-210, Sept. 1948.

(From the Neuropsychiatric Service, Suching Veterans Administration Hospital, Framingham, Massachusetts.)

The activity in a new hospital is described with respect to the various units, including the acute psychosis unit, the neurosis unit, the psychiatric consultation unit, the neurological unit, and the auxiliary units. The training of residents is also discussed.

Zimmerman, F. H., Gallavan, Mae, and Eaton, M. T., Jr.: The cephalincholesterol flocculation test in schizophrenia. Am. J. Psychiat. *105:* 225-226, Sept. 1948.

(From Department of Psychiatry and Department of Pathology, Colorado State Hospital, Pueblo, Colorado.)

After testing 175 consecutive cases diagnosed as schizophrenia, using the cephalin cholesterol flocculation test of Hangar, the authors conclude that this test would not be of help in the differential diagnosis of or the subclassification of schizophrenia in its established stages.

Cuningham, Kathleen, and Smith, K. V.: A case of intussusception caused by endometriosis of ileum. Brit. J. Surg. *36:* 50-51, July 1948.

(From Department of Pathology, University of Sydney, Australia.)

A case is reported and the relative infrequency with which endometriosis affects the ileum is noted.

BOOK REVIEWS

(EDITOR'S NOTE:—*These reviews represent the individual opinions of the reviewers and not necessarily those of the members of the Editorial Board of this* JOURNAL.)

PHYSIOLOGIC THERAPY IN RESPIRATORY DISEASES. By Alvan L. Barach, M.D., Associate Professor of Clinical Medicine, Columbia University College of Physicians and Surgeons; Assistant Attending Physician, Presbyterian Hospital, New York.. 2nd edition. 408 pp. 74 illustrations. Price $7.00. J. B. Lippincott Company, Philadelphia, 1948.

This book gives an excellent account of the uses of oxygen, antibiotics, and many other drugs in cardiorespiratory diseases.

A brief chapter on the historic background is followed by two chapters discussing the physiology of anoxia. The major portion of the book is devoted to specific pulmonary diseases and dysfunctions and each chapter gives the pathological physiology and physiological therapy of the particular syndrome discussed. Because of the method of presentation of this part there is a tendency to repetition and overlapping of subject matter. Possibly this is a good point rather than a weakness of the text: certainly it makes for easy accessibility of the information.

The latter part of the book is given to directions concerning methods of oxygen therapy, use of masks and respirators, care of equipment, and other allied subjects. The suggestions should be helpful to the nursing and technical staffs in the supervision of therapy.

Bronchial asthma has been treated in great detail, making this one of the best chapters. The section on tuberculosis is interesting since it presents a special technique for achieving rest of both lungs without collapse therapy, by means of the equalizing pressure chamber.

Another chapter of great practical interest is the one on Aerial Transportion of Patients with Pulmonary and Cardiac Disease.

Dr. Barach is a leader in the field of inhalation therapy. Since his book correlates therapy with the pathologic physiology of the disease it should prove to be of great value in the treatment of diseases of the cardiorespiratory system.

—Zohora Ismael, M.D.

SYNOPSIS OF PEDIATRICS. By John Zahorsky, A.B., M.D., F.A.C.P., Professor of Pediatrics and Director of the Department of Pediatrics, St. Louis University School of Medicine, and Pediatrician-in-Chief to the St. Mary's Group of Hospitals; Fellow of the American Academy of Pediatrics. Assisted by T. S. Zahorsky, B.S., M.D., Senior Instructor in Pediatrics, St. Louis University School of Medicine, and Assistant Pediatrician to the St. Mary's Group of Hospitals. 5th edition. 449 pp., 158 text illustrations, and 9 color plates. Price: $5.50. St. Louis. The C. V. Mosby Company, 1948.

This synopsis of pediatrics appears in its fifth edition, brought up to date in prophylaxis and treatment, fields in which there has been rapid progress. Procedures that have proved their value have been included; those which are outdated and controversial have been omitted. The text is concise and clear. The 489 pages are divided into sixty chapters, each of which would consume an hour's work in the classroom. The illustrations supplement the text, the procedures being frequently illustrated in place of long descriptions.

The original edition of the work was undertaken to give the medical student and the practitioner the essential points of symptomatology, diagnosis, and treatment. There is no attempt to make this a reference text for the pediatrician; but it should prove of particular value to the medical student and to the general practitioner as a handbook which adequately covers conditions in infants as they occur in the home. The appendix of doses of the most frequently used drugs is of great practical value.

—Julia Mehlman, M.D.

DISEASES OF THE NOSE, THROAT AND EAR. By William Lincoln Ballenger, M.D., F.A.C.S., Late Professor, School of Medicine, University of Illinois, Chicago; and Howard Charles Ballenger, M.D., F.A.C.S., Associate Professor and Acting Chairman of the Department of Otolaryngology, Northwestern University School of Medicine, Chicago; assisted by John Jacob Ballenger, B.S., M.D., Research Fellow in Otolaryngology, Northwestern University School of Medicine, Chicago. 9th edition, thoroughly revised. 993 pp., with 597 illustrations and 16 plates in color. Price: $12.50. Lea and Febiger, Philadelphia, 1947.

Ballenger's Diseases of the Nose, Throat and Ear has been a standard text and reference book on otolaryngology for many years and this ninth edition maintains the excellence of its predecessors. The book has been brought completely up to date, with inclusion of several new subjects. Among these additions are a chapter on rhinoplastic reconstruction and an excellent discussion on headache and neuralgia of the face and neck. This and the chapter on allergy in the nose and throat should be of interest both to the specialist and to the general practitioner. The book is well organized, well balanced, and clearly illustrated. The current trends in otolaryngology as presented in recent literature are well selected and the many references are useful for those who seek access to the original articles. The new Ballenger should prove valuable in any medical library.

—Emily Lois Van Loon, M.D.

Opportunities for Medical Women

A BUSMAN'S HOLIDAY

At the AMA last year during a luncheon with Chinese doctors it was suggested half seriously and half facetiously by the Chinese doctors that American women physicians take a busman's holiday in China, spending two, three, six months, or a year doing medical work at a hospital or at a medical school in that country. This year one of our American women physicians said to me: "Do you think it would be possible to spend a vacation at a hospital in China, thus combining the pleasure of travel with some medical work in a foreign country?" Almost simultaneously a letter from a doctor in China states: "Gradually we are assembling nurses until we will soon have a working staff. *I do need another good doctor* and if we could have a lab technician-x-ray technician combination it would go a long way toward making us a real hospital."

There is presented therefore the interesting possibility of arranging a vacation service in a foreign country. Would it be possible to work out such a program through one of the standing committees (Hospital Committee) of the American Medical Women's Association? The arrangements should be done in such a manner that the doctors in this country would know when and where vacancies in foreign countries occur and the foreign hospitals should know the credentials of the doctors contemplating a visit.

If anyone is specifically interested in the above "need for a good doctor," she may address Dr. V. V. Brown, Scott-Thresher Memorial Hospital, Swatow, China. H. E. Thelander, M.D.

OPPORTUNITIES FOR PHYSICIANS IN GERMANY AND JAPAN

(Administrative positions in the field of public health)

The army is at present endeavoring to procure the services of physicians for administrative positions in the field of public health. The nature of the work is largely supervisory and the areas now in need are Germany and Japan. The salary currently being offered is $9,000.00. The army will provide transportation. Any doctor who undertakes such employment agrees to remain in the service for a period of at least two years. He will retain civilian status and will be a civil employee of the Army. These positions are open to women physicians: (in Japan, somewhat restricted by certain requirements necessitated by Eastern conditions.)

I. MEDICAL OFFICER (Chief of Branch)—BERLIN

Duties:

1. Supervises all Public Health activities undertaken by the Germans for the population of the city of Berlin (American Sector) including: hospitalization; hospital reconstruction; preventive medicine and epidemiological activities; sanitation; food, dairy, and meat hygiene; organization of professional associations; vital statistical compilations and analysis; estimation of requirements of medical and sanitation supplies; professional recommendations regarding nutritional status of population; establishment and enforcement of narcotic control matters; and in general coordinating Public Health operations, as U. S. Public Health representative of the Allied Kommandatura for the City of Berlin. This also entails submission of recommendations for any proper establishment of policies and procedures for coordinated Public Health operations within the City of Berlin to higher authority.

2. Supervises and controls civilian Public Health authorities to insure that such authorities provide the measures of civilian health control necessary for the protection of our forces, as: venereal disease control, case finding, and compulsory treatment; typhoid and typhus fever control, notation, and case finding.

3. Represents the United States at the meetings of the Public Health Committee of the Inter-Allied Kommandatura of Berlin.

4. Coordinates epidemiological activities of civilians with those of the Medical Department of US Army in Berlin, furnishing essential and timely information, statistics, and recommendations.

5. This position can be filled only by a qualified Doctor of Medicine, who has had special training in Public Health or its equivalent in practical experience.

Qualifications:

He must be a graduate Doctor of Medicine. He must have had considerable training in public health and administration or in lieu thereof have had equivalent practical experience in these fields. He must be of the highest caliber not only intellectually but personally as well, if he is to fulfill the task of representing the U.S. on a quadripartite body.

II. MEDICAL OFFICER—BERLIN

Duties:

1. Substitutes for the Chief as the United States representative on the Public Health Committee of the Allied Kommandatura Berlin. The Public Health Committee meets at least once each week and has as many special sessions as the situation requires to consider public health problems of the City of Berlin

on a quadripartite basis. As Deputy Chief, this officer attends all sessions with the Chief and in his absence substitutes for him. Since the Public Health Committee consists of the four public health officers of the occupying powers and their technical staffs, the Deputy is required to study all public health problems in conjunction with the Chief and be thoroughly familiar with the policies, plans, and desires of higher headquarters, as is the Chief. He is required to make special studies and reports as the technical assistant to the Chief. Since for one month every quarter, the US holds the Chairmanship, if there is an unavoidable absence of the Chief, the Deputy Chief must substitute in the Chair for him. This entails the preparation of an agenda, minutes, reports, recommendations to the Deputy Commandants and Commandants, orders to the Oberbuergermeister, technical instructions to the Public Health Department of Berlin, and all other secretarial work connected with Quadripartite Government.

2. Supervises and inspects the operation of all hospitals in the US Sector of Berlin. This includes inspections of administration to insure that competent personnel are in charge, that de-Nazification is carried out, and that personnel undesirable to Military Government are not holding responsible staff positions. It includes the technical inspection of the facilities of the hospitals when reports are made of serious deficiencies.

3. Directs, where necessary, that approved methods be used in the prevention and control of communicable diseases in the US Sector of Berlin. In this regard he must supervise the collection of proper statistics regarding sanitary control measures such as water, sewerage, refuse, insect and rodent control operations; control of refugee camps and centers; dairy, meat, and food hygiene; and communicable disease statistics. Along with the Chief, on the basis of information obtained, he assists in formulating and issuing such orders concerning public health operations as are applicable only to the US Sector of Berlin.

4. Coordinates the activities of military and civilian Police and Health Department employees in the Venereal Disease Control Program. This entails regular inspection of the approved Venereal Disease diagnostic centers, detention centers, and treatment centers in hospitals. He must keep himself informed in regard to the efforts and methods used in tracing named contacts who have infected US or Allied personnel and see to it that such contacts are located, detained, diagnosed, and where necessary forcibly treated. He must attend meetings of the Venereal Disease Control Board of the US Army.

5. Establishes priorities on the use of available materials for the repair of hospitals and directs the allocation of beds for specific use. This also entails his collecting data on medical supply problems, obtaining estimated needs of civilian medical supplies, directing activities in cooperation with the Trade and Industry Section concerning re-establishment of local manufacturers of medical supplies and aiding in procuring them so that the required reconstruction of hospitals when completed will have the necessary materials with which to operate.

Qualifications:

He must be a graduate doctor of medicine. He must have had considerable training in public health and administration or in lieu thereof have had equivalent practical experience in these fields. He must be of the highest caliber not only intellectually but personally as well if he is to fulfill the task of representing the United States of America on a Quadripartite body.

III. MAJOR PREFECTURAL PUBLIC HEALTH OFFICER—JAPAN

Duties:

1. Will be assigned as public health officer to a prefectural or special area military government team.

2. Will be responsible for all public health activities of military government within the prefecture or special areas.

3. Will be supervised administratively by the commanding officer of the military government team assigned.

4. The individual will supervise and give surveillance to Japanese health officials of prefectural and city governments with regard to the manner of the performance of the following:

a. Compliance with all SCAP memorandums relative to public health activities.

b. General public health and sanitation program.

c. Organization, training, and operation of civilian sanitation squads for insect and rodent control and environmental sanitation.

d. Immunization program in compliance with existing regulations.

e. Hospitalization and medical care for the Japanese.

f. Quarantine and general control measures for the major epidemic diseases.

g. Prompt and accurate reporting of communicable diseases with special attention to the major epidemic diseases.

h. Venereal disease treatment and control program.

i. Distribution and use of medical supplies and insect and rodent control supplies and equipment.

5. The individual will review Japanese health measures and lend necessary advice and technical assistance to the Japanese public health officials in planning future public health activities.

For further information regarding the above opportunities, apply to the Overseas Affairs Branch, Civilian Personnel Division, Office of the Secretary of the Army, The Pentagon, Washington 25, D. C.

OPPORTUNITIES IN U. S. CIVIL SERVICE

Medical Officer Examinations Announced

The U. S. Civil Service Commission has announced an examination for filling Medical Officer (Rotating Intern and Psychiatric Resident) positions in St. Elizabeth's Hospital, Washington, D. C. Medical Officers, (Rotating Intern) are paid $2,200 for the first year and $2,400 for the second year. Medical Officers (Psychiatric Resident) are paid from $2,400 to $4,100 a year, depending upon the amount of approved postgraduate training the applicant has completed. Appointments are open for July 1, 1949. Internships consist of two years of rotating service, and Psychiatric Residencies consist of one to three years in psychiatry. To qualify for Internships applicants must be third or fourth year students in an approved medical school; however, they may not enter on duty until they have successfully completed the full course of study. Applicants for Psychiatric Residencies must be graduates of an approved medical school, with the degree of doctor of medicine, and, in addition, they must have completed an approved internship or must now be serving such an internship. No written test is required for the Medical Officer positions. Details about the requirements are given in the examination announcements.

Examination for filling Medical Officer positions in Washington, D. C., throughout the United States, and in the Panama Canal Zone, at salaries ranging from $4,479 to $6,235 a year has been announced

by U. S. Civil Service Commission, Washington, D. C. No written test is required to qualify for the positions. Applicants must be graduates of a medical school and must be currently licensed to practice medicine and surgery. (The requirement of a current license will be waived for certain persons and positions.) For positions paying $4,479 and $5,232, applicants must have completed a full internship, either general rotating or in a specialty (this requirement is waived for some positions); and for positions paying $5,232 and $6,235, they must have had professional medical experience. Maximum age limits for these positions are as follows: For Panama Canal Service, 45 years; for Indian Service, 50 years; for other agencies, 62 years. For persons entitled to veteran preference, the 45- and 50-year age limits are waived to 62 years and the 62-year age limit is waived without limitation. Detailed information is given in the announcement.

Interested persons may obtain information and application forms from post offices, Civil Service regional offices, or the U. S. Civil Service Commission, Washington 25, D. C. Applications will be accepted in the Commission's Washington office until further notice.

OTHER OPPORTUNITIES

The Illinois Department of Public Health needs District Health Officers. Salary range $5,760-$6,960, plus travel. Liberal retirement system. Those with experience preferred and will start above minimum salary, with regular raises for satisfactory service. Qualified individuals may be placed in Division Offices of State Department. Possibility of positions in newly established city and county health departments paying approximately $7,000 plus travel, or higher. Only graduates of Class A medical schools and AMA approved internships considered. Applicants must be willing to take special training on stipend if indicated. Write: Roland R. Cross, M.D., Director State Department of Public Health, Springfield, Ill.

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Postgraduate Public Health Fellowships. A limited number of fellowships are available to physicians for one year of postgraduate study leading to a Master of Public Health degree. This study requires one academic year at a school of public health approved by the American Public Health Association, followed by 3 months of acceptable or approved field training. Awards are based on the individual need of each applicant. Fellowships may cover tuition, maintenance, and an allowance for books, if required. For further information write to: National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N. Y.

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The Foundation Prize. The South Atlantic Association of Obstetricians and Gynecologists announces the establishment of the Foundation Prize. Authors of papers on obstetric or gynecologic subjects desiring to compete for the prize may obtain information from Dr. E. D. Colvin, secretary-treasurer, 1259 Clifton Road, N. E., Atlanta, Georgia.

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Research Grants Public Health Service. The extensive research grants program of the Public Health Service is administered by the Division of Research Grants and Fellowships of the National Institute of Health. Three councils—the National Advisory Health Council, the National Advisory Cancer Council, and the National Advisory Mental Health Council—authorized by Congress, recommend to the Surgeon General the granting of funds to assist "universities, hospitals, laboratories, and other public or private institutions, and individuals" in advancing medical and scientific knowledge.

On receipt of inquiries, the Division supplies either institutions or an individual scientist with application blanks and instructions to submit an outline of the proposed research project for which a grant is desired. Study sections, composed of consultants who have achieved national recognition in their fields, evaluate the scientific ability of applicants and suitability of their proposed research projects. On the basis of study section findings, the appropriate National Advisory Council recommends final action on each grant application.

To the Division of Research Grants and Fellowships are detailed the administrative functions such as processing papers, paying grants, and keeping pertinent records, and the analysis of reports in connection with various funds allotted.

ORGANIZED STUDY SECTIONS ON RESEARCH GRANTS

Antibiotics.
Bacteriology.
Biochemistry and Nutrition
Cardiovascular Diseases.
Dentistry.
Cancer.
Gerontology.
Hematology.
Malaria.
Mental Health.
Metabolism and Endocrinology.
Pathology.
Pharmacology.
Physiology.
Public Health Methods.
Radiobiology.
Sanitation.
Surgery.
Syphilis.
Tropical Diseases.
Virus and Rickettsial Diseases.
Tuberculosis.

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Nutrition Awards. The American Institute of Nutrition will make three awards to investigators at its annual meeting next spring. The 1949 award of $1,000 established by Mead Johnson and Company will be given to the laboratory (non-clinical) or clinical research worker in the United States or Canada who has published during 1948 the most meritorious scientific report dealing with the field of the B-complex vitamins. While the award will be given primarily for publication of specific papers, it may be recommended that it be made to a worker for contributions over an extended period. The Borden Award in Nutrition, $1,000 and a gold medal, made available by the Borden Company Foundation, Inc., will be given in recognition of distinctive research by investigators in the United States and Canada which has emphasized the nutritive significance of the components of milk or of dairy products. The award will be made primarily for publication of specific papers. The Osborne and Mendel Award of $1,000, established by the Nutrition Foundation, Inc., for the recognition of outstanding accomplishments in the general field of exploratory research in the science of nutrition, will be given to the investigator who is judged to have made the most significant published contribution in the year. While preference will be given to research workers in the United States and Canada, investigators in other countries are not excluded. Nominations for these awards must be in the hands of the chairman of the nominating committee by January 15, 1949. They should be accompanied by such data relative to the accomplishment of the nominee and his research as will facilitate the task of the committee of judges. Nominating committee chairman for the Mead Johnson Award is Harold H. Williams, Cornell University, Ithaca, N. Y.; for the Borden Award, James M. Orten, Wayne University College of Medicine, Detroit 26, and for the Osborne and Mendel Award, D. W. Woolley, Rockefeller Institute for Medical Research, New York.—(J.A.M.A. Oct. 16, 1948.)

Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

ASSOCIATION NEWS AND ANNOUNCEMENTS

REGISTER NOW FOR ANNUAL MEETING IN JUNE

The Annual Meeting of the American Medical Women's Association will be held on June 4-5, 1949, at the Hotel Dennis in Atlantic City, New Jersey. It is advisable to make your reservation for this meeting immediately. If you wish to stay over for the American Medical Association meetings it will be necessary to send in the American Medical Association registration blank which will later appear in the Journal of the American Medical Association.

Those who are registered at the Hotel Dennis for the American Medical Women's Association meetings will be given first consideration in having their stay extended through the meetings of the American Medical Association.—HANNAH E. SEITZICK-ROBBINS, M.D., *Chairman of Arrangements, Annual Meeting.*

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MEDICAL WOMEN'S LIBRARY AND MEMORIAL FUND

Say It With Insurance

Antoinette Le Marquis who graduated from the Loyola University School of Medicine in 1940 and who followed with an internship in the Los Angeles General Hospital is now practicing in San Diego, California. Before studying medicine Dr. Le Marquis was an executive trained nurse with a knowledge of the modern languages. With this training in the humanities it is not surprising that when she came to Chicago last June to attend the meetings of the A. M. W. A. and the A. M. A. she took out an insurance for the trip and made her beneficiary the Medical Women's Library and Memorial Fund.

Dr. Le Marquis is a life member of the A. M. W. A. and when a medical student she took advantage of the student Loan Fund to complete her medical education and liquidated the indebtedness in record time.

The Campaign Committee of the Medical Women's Library and Memorial Fund take this opportunity to thank the eight year old member, Dr. Le Marquis, for her loyalty and thoughtfulness, and to beg her fellow members to follow her example and, when travelling, to take out insurance, naming as beneficiary the Medical Women's Library and Memorial Fund.

BERTHA VANHOOSEN, M.D.
Chairman, Library Committee

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NEWS FROM THE BRANCHES

Two, Chicago

Branch 2 of the American Medical Women's Association held a joint professional meeting on October 6 with the Women's Bar Association. The subject of the evening was "Youth and its Problems" and the various aspects of this topic were discussed by the following speakers:

The Juvenile Court Act and Its Need for Amendment, Mrs. Virginia Lehmann, attorney, Legal Aid Bureau.

Social Aspects of Juvenile Court Work, Miss Irene Kawin, Deputy Chief Probation Officer, Juvenile Court of Cook County.

Juvenile Problems as Viewed by a Child Psychiatrist, Dr. Sophie Schroeder-Sloman, acting Superintendent, Institute of Juvenile Research.

Childhood Problems and Juvenile Delinquency, Miss Iva Aukes, psychiatric social worker, Illinois Society of Mental Hygiene, and Miss Pearl Hart, attorney.

Fourteen, New York City

Dr. Martha M. Eliot, Associate Chief of the Children's Bureau, and one of the U. S. delegates to the first World Health Assembly, was the speaker at the dinner of the Women's Medical Association of New York City on October 27th—her subject "The World Health Organization."

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TO THE BRANCH SECRETARIES

The Editor of the JOURNAL asks that Branch Secretaries send their programs for the coming year for publication in the Journal. The time, place, and date of the meetings should be given, the topics to be discussed, etc. These notices should be sent direct to the Editor, Dr. Ada Chree Reid, 1 Madison Avenue, New York 10, N.Y. It is believed that the programs will be of interest to all and of help to the officers of other branches.

Medical Women in the News

Dr. Adele Hampton, who was called "the Mother of the Dade County (FLORIDA) Medical Association," recently resigned her position as executive secretary of that Association. Over twenty years ago Dr. Hampton offered her assistance in the establishment of a telephone exchange, and since that time she has been extremely active in the organizational work of the Association.

* * *

Dr. Angie Connor, recently associated with the Children's Heart Association in Cincinnati, began duties July 1 as clinical pediatrician in the Bureau of Maternal and Child Health and Crippled Children of HAWAII. She is a graduate of Woman's Medical College of Pennsylvania, Philadelphia, 1937.

* * *

Dr. Gilda Peraza of CUBA, one of the vice-presidents of the International Federation of Business and Professional Women—attended an Executive Committee meeting of that organization which was held in New York in October.

* * *

Dr. Dorothea Lemcke of NEW YORK has been appointed chief medical officer of Long Lines Department, American Telephone and Telegraph Co., New York, N. Y. There are 10,356 employees, 7,660 of whom are women, in the department. The second woman ever to interne at New York Hospital, Dr. Lemcke, is a physician in the Out Patient Department of the New York Hospital-Cornell Medical Center.

* * *

Dr. Henrietta Herbolsheimer has been appointed Medical Administrative Assistant to Roland R. Cross, M.D., Director of the ILLINOIS Department of Public Health. A member of the staff of the department for 7 years, she has been Chief of the Division of Hospital Construction and Services for the past year, and earlier Chief of the Division of Maternal and Child Health.

* * *

In the re-organization of the NEW YORK CITY Department of Health, Dr. Leona Baumgartner will direct the work of the four bureaus:—Mothers and Young Children, Physically Handicapped Children, Dentistry, and School Health. Dr. Baumgartner, who joined the department in 1937, has been Director of its Bureau of Child Hygiene since 1941.

* * *

Dr. Phyllis Cilento of QUEENSLAND, AUSTRALIA, has come to New York with part of her family to join her husband, Sir Raphael Cilento, who is with the United Nations staff. She has recently been attending the Post-Graduate Fortnight of the New York Academy of Medicine.

* * *

At a luncheon sponsored by the New York League of Business and Professional Women, Dr. K. Frances Scott, president of the National Federation, was a speaker. The luncheon was held at the Biltmore Hotel in NEW YORK and marked the opening of National Business Women's Week.

* * *

A new office that will function as a clearing house of information on medical and other types of research relating to children's health and welfare has been set up in the Children's Bureau, Federal Security Agency. Clara E. Councell has been appointed director of the unit, which will be under the general supervision of Dr. Martha M. Eliot, associate chief of the Bureau.

* * *

Among the first 288 women officers who have been selected for commissions in the regular NAVY under the provisions of the Women's Armed Services Integration Act of 1948 are 2 in the Medical Corps, 21 in the Medical Service Corps and 1 chief warrant officer in the Hospital Corps. The two in the Medical Corps are Lieutenant Commander Frances Lois Willoughby of Washington, D. C., a graduate of the University of Arkansas School of Medicine, LITTLE ROCK, and Lieutenant Gioconda Rita Saraniero of Brooklyn, New York, a graduate of the Woman's Medical College of Pennsylvania, PHILADELPHIA.

* * *

Dr. Hilda M. Lazarus, Director-Principal of Vellore Christian Medical College, VELLORE, SOUTH INDIA, was guest of honor at a tea, September 28, at St. Bartholomew's Community House, New York. Dr. Lazarus is correspondent from South India to the Journal of the AMWA.

LOUISE PEARCE, M.D.

Medical Woman of the Month

LOUISE PEARCE early acquired her love of far away places and her breadth of vision. Born in Massachusetts, she obtained her preparatory and college education in California and then came East to enter the medical school of Johns Hopkins. That stimulating atmosphere developed her scientific curiosity and she often speaks of the great teachers at Johns Hopkins and their influence upon her training and upon all medical education.

Louise Pearce, M.D.

After a year as house officer at the Hopkins Hospital, she joined the staff of the Rockefeller Institute for Medical Research. Here she began the research that was to take her into many fields and countries. Her research interests have been as varied as her geographical background. The Institute sent her to Africa to conduct the African Sleeping Sickness Mission and in recognition of her work in the Belgian Congo she received the Order of the Crown of Belgium. She spent two years as visiting Professor of Medicine at the Peiping Union Medical College. A visit to her colony of rabbits in the laboratories of the Rockefeller Institute in Princeton is an enjoyable and amazing experience. The organization of the huge colony, the files and records, the accumulation of slides and data, and the studies of the Brown-Pearce tumor are impressive. Her work on experimental syphilis and her investigations on constitutional and environmental factors in resistance and susceptibility to disease are classics in their fields.

She belongs to many societies and has received many honors. The list from the early Phi Beta Kappa through the latest D.Sc. is a long one.

Dr. Pearce is no scientific recluse; she is a woman and a citizen as well as a scientist. She likes jewelry and hats, fishing and dancing. Her social conscience and convictions are notable. Her work in Africa and China and her many visits to England and the continent have given her an international perspective not only in science but in education, politics, and world affairs. In the American Association of University Women she has been one of the leaders in international policies and has been especially interested in the foreign fellowships granted by the Association. Her influence in the advancement of women in professional and educational fields has been felt in many organizations, among which is the American Medical Women's Association. As President of the Woman's Medical College of Pennsylvania she has stimulated the faculty and students with the wealth of her experience in medicine and science and with her wide acquaintance with scientists and physicians.

When she moved her laboratory to Princeton, Dr. Pearce and her two friends, Dr. S. Josephine Baker and Miss Ida A. R. Wylie, set up a household together. At Trevenna Farm there is hospitality for visitors from all over the world. Dr. Pearce's library with its old editions of medical treasures, the latest books on international and scientific questions, and a fine collection of porcelain and carvings from China is a picture of her life—a gracious blend of art, science, literature, and humor.

NEWS FROM WOMAN'S MEDICAL COLLEGE

Formal Opening Day exercises of the Woman's Medical College were held on Wednesday, September 15. The chief address was given by Clarence E. Pickett, executive secretary since 1929 of the American Friends Service Committee, who spoke on "The Social Obligation of the Scientist." On the rostrum were Dr. Louise Pearce, president of the College, who presided; Dean Marion Fay, who gave the welcome; Dr. Katharine Boucot, who spoke on behalf of the Alumnae Association; Dr. Hartwig Kuhlenbeck, professor of anatomy and chairman of Faculty Council; Donald C. Rubel, chairman of the Board of Corporators; and Dr. Catharine Macfarlane, who presented four volumes of Pernkoff's "Topographical Anatomy" which were given to the College by Dr. Andreas Plenk, of Austria. Immediately following the Opening Day program was the presentation of a new bronze plaque for the vestibule which lists the names of those donors of $500 and over, whose gifts in 1930 made possible, in part, the erection of the present College buildings. This plaque was the gift of Dr. Catharine Macfarlane, who gave the dedicatory address. The student body now numbers 161. The entering class of 50 students was selected from 335 applicants and represents 19 states and 1 foreign country.

* * *

On Saturday, October 2, the College held Open House for members of the Federated Women's Clubs of Philadelphia, in celebration of "Pennsylvania Week." The guests toured the building from 3 to 4 in the afternoon. At 4 o'clock Mrs. John Y. Huber, chairman of the Women's Committee for the Celebration of Pennsylvania Week spoke. Dr. Katharine Boucot spoke on behalf of the alumnae. Judge Francis F. Burch of the Philadelphia Boosters' Association presented the College with a flag of the Commonwealth of Pennsylvania, which was accepted by Dean Marion Fay. Tea was served in the students' lounge.

* * *

Among the research grants recently renewed to members of the Woman's Medical College faculty are: from the American Cancer Society $3,045 to Dr. E. Frances Stilwell, associate professor of anatomy, for continuation of her tissue culture work on multiple mitoses in relation to malignancy; from the United States Public Health Service $4,514 to Dr. Ruth E. Miller, professor of bacteriology, for continuation of work on the effect of immune reactions on bacterial metabolism; and to Dr. Harold Israel, clinical associate professor of medicine, $3,240 for continuation of a study on BCG vaccination in sarcoidosis.

* * *

Dr. M. Louise C. Gloeckner (Woman's Medical College, 1928) of Conshohocken, Pa., was recently elected a vice-president of the Pennsylvania State Medical Society. * * * Dr. Ann Tomkins Gibson (Woman's Medical College, 1910) has been appointed professor of hygiene and student health physician at Wilson College, Chambersburg, Pa. She succeeds Dr. Sarah I. Morris (Woman's Medical College, 1910) who has become the assistant director of the Tuberculosis Control Bureau of the Pennsylvania State Department of Health. * * * Dr. Althea D. Kessler (Woman's Medical College, 1938) is assistant professor of pediatrics at Howard University, School of Medicine.

* * *

The Woman's Medical College has been named beneficiary for three legacies: under the will of Dr. Margaret J. Delmore, class of 1899, Uniontown, Pa., in the amount of $47,000, the income of which is to be used for scholarships; in the amount of $17,000 under the will of Dr. Grace W. Sherwood, class of 1904, St. Albans, Vt., also for scholarship purposes; and in the amount of $5,000 from a trust under the will of Redwood F. Warner, an outright gift.

OBITUARY

ANNIE GALLOWAY LYLE, M.D.

Dr. Annie G. Lyle, widely known physician of San Francisco, died in the Franklin Hospital in that city, on October 7, 1948, after a long illness, aged 79 years. Dr. Lyle was a member of the first class to graduate from Leland Stanford University, where she was a classmate of former President Hoover, and later was admitted to the Johns Hopkins University School of Medicine, one of the first women to be received. She graduated from that school in 1902 and continued her studies at the Royal University of Vienna, where she served as assistant professor for some years. Returning to San Francisco, her birthplace, she then established herself in the practice of gynecology and obstetrics, and also became deeply interested in work among children. She assisted in the founding of the first juvenile court in San Francisco and was active as well in many other civic matters. Dr. Lyle was a member of the American Medical Association, the State and County Medical Societies, and a number of women's clubs.

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INDEX

A

Action is a remedy, (Riddle), 118
AMERICAN MEDICAL WOMEN'S ASSOCIATION:
  American Women's Hospitals, 61, 103, 106, 380
  Annual Meeting, 1948, proceedings, 374, 523
    Social activities, 332
  Board of Directors, meeting, 60, 109, 374
  Branches, news and reports, 112, 170, 216, 253, 385, 467, 521
  Committee reports:
    American Women's Hospitals, 61, 380
    Brochure, 65
    Constitution, revision, 384
    Elections, 65, 375, 382
    Emergency aid for women physicians, 62, 376, 384
    Finance, 62, 377
    History of medicine, 377
    International relations, 63
    Legislation, 63, 377
    Library, 63, 378
    Medical education for women, 381
    Nominating, 64, 171
    Opportunities for medical women, 64, 379
    Organization and membership, 64, 379
    Public health, 64, 379
    Public relations, 64, 379
    Publication, 64, 379
    Reference, 380
    Scholarship awards, 64, 380
    Scholarship funds, 380
    Woman's Medical College of Pennsylvania, 64, 380
    Woolley Memorial, 65, 382
  International corresponding secretary, report, 65, 383
  Library, Medical Women's (Van Hoosen), 436, 521
  Mid-year board meeting, 60, 109
  New members, 27, 65, 113, 216, 253, 298, 333, 362, 467
  Opportunities for medical women, 28, 67, 114, 172, 220, 255, 300, 337, 364
  President, message (Gardner), 109, 170, 215 (L'Esperance), 297, 332, 362, 466
  President, report (Gardner), 60, 297, 374
  Regional directors, reports, 111, 383
  Secretary, corresponding, report, 60, 374
    recording, 375
  Treasurer, report, 60, 376
American Women's Hospitals in France (Lovejoy), 103
  in Greece (Lovejoy), 106
Andersen, Karen, Report on BCG vaccinations in Copenhagen, 399
Anderson, Evelyn, and Haymaker, Webb, Influence of hypothalamus on sexual function, 402, 457
Anesthesia, recent advances in (Wells), 53
Ann Preston: Physician (Sturgis), 509
Apoplexy, vesical (Mulholland), 502
Argentina, news from, 428
Arthropods as agents and vectors of disease (Birch), 93
Asirvatham, Josephine, Obstetrical service in India, 411
Associate members, word to, 468
Australia, news from, 428
Austria, news from, 428

B

Bader, Genevieve M., Strang Clinic, Memorial Hospital, statistical report, women's division, 132
Bauer, L. H., World Medical Association, 426
Baumgartner, Leona, Public Health Nurse, 107
BCG vaccinations in Copenhagen (Andersen), 399
Bedarida, Lucia, Proposal for International University, 105
Biochemical disturbances accompanying gastroduodenal disease (Gray), 389
Biopsies, technique of, for diagnosis of cancer (Scharnagel), 142
Birch, Carroll L., International Society of Hematology, 462
  Tropical Medicine, Part XV, Platyhelminthes, 6
    Part XVI, Trematoda, 8
    Part XVII, Mycotic diseases, 48
    Suppl., Helminth ova and arthropods, 93
Blood, International Society of Hematology (Birch), 462
Boeck's sarcoid (O'Connor), 504
Bogatko, Frances H., Strang Clinic, Memorial Hospital, statistical report, women's division, 132
Bonser, Georgiana, Fourth International Cancer Congress, 24
BOOK REVIEWS:
  Abdomen, Surgical Treatment of (Bancroft and Wade), 309
  Adler, F. H., Gifford's Textbook of Ophthalmology, 123
  American Illustrated Dictionary (Dorland), 122
  Anatomy, Concise (Edwards), 78
  Atlas of Cardiovascular Disease (Treiger), 78
  Bacterial Diseases, Acute (Dowling), 348
  Ballenger, W. L., Diseases of Nose, Throat and Ear, 517
  Bancroft, F. W., Surgical Treatment of Abdomen, 309
  Barach, A. L., Physiologic Therapy in Respiratory Diseases, 517
  Barborka, C. J., Treatment by Diet, 436
  Bastedo, W. A., Pharmacology, Therapeutics, and Prescription Writing, 123
  Beckman, H., Treatment in General Practice, 347
  Bond, E. D., Dr. Kirkbride and his Mental Hospital, 78
  Bone and Bones, Fundamental of Bone Biology (Weinmann and Sicher), 35
  Burch, G. E., Primer of Cardiology, 177
  Cardiology, Primer of (Burch and Reaser), 177
  Cardiovascular Diseases, Atlas of (Treiger), 78
  Cecil, R. L., Textbook of Medicine, 79
  Christopher, F., Minor Surgery, 308
  Clinical Neurology (Wechsler), 268
  Clinical Psychiatry (Ebaugh), 177
  Clinical Psychiatry, Modern (Noycs), 480
  Communicable Diseases (Top), 35
  Congenital Malformations (Murphy), 223
  Correlative Neuroanatomy (McDonald and others), 480
  Crosse, V. Mary, Premature Baby, 34
  Crossen, H. S., and R. J., Operative Gynecology, 347
  Cutting, W. C., Manual of Clinical Therapeutics, 308
  Diagnosis in Daily Practice (White and Geschickter), 122
  Diagnosis in Gynecology (Ricci), 435
  Diet, Treatment by (Barborka), 436
  Disability Evaluations (McBride), 309
  Diseases affecting the Vulva (Hunt), 371
  Diseases of Ear, Nose and Throat (Morrison), 435
  Diseases of Nose, Throat and Ear (Ballenger), 517
  Diseases of Metabolism (Duncan), 223
  Dr. Kirkbride and his Mental Hospital (Bond), 78
  Dorland, W. A. N., American Illustrated Medical Dictionary, 122
  Dowling, H. F., Acute Bacterial Diseases, 348
  Duncan, G. G., Diseases of Metabolism, 223
  Ear, Nose and Throat, Diseases of (Morrison), 435
  Ebaugh, F. G., Practical Clinical Psychiatry, 177

Edwards, L. F., Concise Anatomy, 78
Electrocardiography, Unipolar Lead (Goldberger), 308
Elledge, Caroline H., Rehabilitation of Patient, 480
Elliott, H. C., Textbook of Nervous System, 35
Emotional Maturity (Saul), 269
Engrammes of Psychiatry (Nielsen and Thompson), 268
Essentials of Pharmacology (Oldham and others), 177
Etheredge, Maude L., Health Facts for College Students, 122
Ewalt, F. G., Practical Clinical Psychiatry, 177
Ferguson, L. K., Surgery of Ambulatory Patient, 34
Foot and Ankle: Injuries, Diseases, Deformities, and Disabilities (Lewin), 123
Foot, N. C., Identification of Tumors, 480
Frohman, B. S., Brief Psychotherapy, 308
Fundamentals of Psychiatry (Strecker), 79
General Practice, Treatment in (Beckman), 347
Geschickter, C. F., and White, B. V., Diagnosis in Daily Practice, 122
Gifford's Textbook of Ophthalmology (Adler), 123
Goldberger, E., Unipolar Lead Electrocardiology, 308
Gynecology, Diagnosis in (Ricci), 435
Gynecology, Operative (Crossen), 347
Gynecology, Practical Office (Karnsky), 269
Health Facts for College Students (Etheredge), 122
History of Medicine (Mettler), 223
Hunt, Elizabeth, Diseases affecting the Vulva, 371
Infant Nutrition (Jeans), 79
Internal Medicine in General Practice (McCombs), 34
Jeans, P. C., Infant Nutrition, 79
Karnsky, K. J., Practical Office Gynecology, 269
Kinsey, A. C., and others, Sexual Behavior in Human Male, 269
Labor, Puerperium, and Newborn, Pathology of (McCormick), 78
Levinson, S. A., Symposium on Medicolegal Problems, 347
Lewin, P., Foot and Ankle, 123
Litzenberg, J. C., Synopsis of Obstetrics, 177
Malformations, Congenital (Murphy), 223
Manual of Clinical Therapeutics (Cutting), 308
McBride, E. D., Disability Evaluations, 309
McCombs, R. P., Internal Medicine in General Practice, 34
McCormick, C. O., Pathology of Labor, Puerperium, and Newborn, 78
McDonald, J. J., and others, Correlative Neuroanatomy, 480
Medicine, History of (Mettler), 223
Medicine in Postwar World, 435
Medicine Today, 347
Medicolegal Problems, Symposium on (Levinson), 347
Metabolism, Diseases of (Duncan), 223
Mettler, Cecilia G., History of Medicine, 223
Mettler, F. A., Neuroanatomy, 435
Minor Surgery (Christopher), 308
Morrison, W. W., Diseases of Ear, Nose and Throat, 435
Muncie, W., Psychobiology and Psychiatry, 348
Murphy, D. P., Congenital Malformations, 223
Muscles, Oculorotary (Scobee), 371
Nervous System, Textbook of (Elliott), 35
Neuroanatomy (Mettler), 435
Neuroanatomy, Correlative (McDonald and others), 480
Neurology, Clinical (Wechsler), 268
Nielsen, J. M., and Thompson, G. N., Engrammes of Psychiatry, 268
Nose, Throat and Ear, Diseases of (Ballenger), 517
Noyes, A. P., Modern Clinical Psychiatry, 480
Nursing (Wolf), 35
Nutrition, Infant (Jeans), 79
Obstetrics, Synopsis of (Litzenberg), 177
Oculorotary Muscles (Scobee), 371
Oldham, F. K., and others, Essentials of Pharmacology, 177
Operative Gynecology (Crossen), 347
Ophthalmology, Gifford's Textbook of (Adler), 123
Pathology of Labor, Puerperium and Newborn (McCormick), 78
Pediatrics, Synopsis of (Zahorsky), 517
Pharmacology, Essentials of (Oldham and others), 177
Pharmacology, Manual of (Sollman), 348
Pharmacology, Therapeutics and Prescription Writing (Bastedo), 123
Pharmacopoeia of the United States, 177
Physiologic Therapy in Respiratory Diseases (Barach), 517
Practical Clinical Psychiatry (Strecker and others), 177
Premature Baby (Crosse), 34
Prescription Writing, Pharmacology, Therapeutics and (Bastedo), 123
Primer of Cardiology (Burch and Reaser), 177
Psychiatry, Engrammes of (Nielsen and Thompson), 268
Psychiatry, Fundamentals of (Strecker), 79
Psychiatry, Modern Clinical (Noyes), 480
Psychiatry, Practical Clinical (Strecker and others), 177
Psychiatry, Psychobiology and (Muncie), 348
Psychobiology and Psychiatry (Muncie), 348
Psychotherapy, Brief (Frohman), 308
Rehabilitation of Patient, Social Casework in Medicine (Elledge), 480
Respiratory Diseases, Physiologic Therapy in (Barach), 517
Ricci, J. V., Diagnosis in Gynecology, 435
Saul, L., Emotional Maturity, 269
Scobee, R. G., Oculorotary Muscles, 371
Sexual Behavior in Human Male (Kinsey and others), 269
Sicher, H., Bone and Bones: Fundamentals of Bone Biology, 35
Social Casework in Medicine, Rehabilitation of the Patient (Elledge), 480
Sollman, Torald, Manual of Pharmacology, 348
Strecker, E. A., Fundamentals of Psychiatry, 79
Practical Clinical Psychiatry, 177
Surgery of Ambulatory Patient (Ferguson), 34
Surgery, Minor (Christopher), 308
Surgical Treatment of Abdomen (Bancroft and Wade), 309
Symposium on Mediocolegal Problems (Levinson), 347
Synopsis of Obstetrics (Litzenberg), 177
Therapeutics, Clinical, Manual of (Cutting), 308
Therapy, Physiologic, in Respiratory Diseases (Barach), 517
Thompson, G. N. and Nielsen, J., Engrammes of Psychiatry, 268
Top, F. H., Communicable Diseases, 35
Treatment by Diet (Barborka), 436
Treatment in General Practice (Beckman), 347
Treiger, I. J., Atlas of Cardiovascular Diseases, 78
Trichomonas Vaginalis and Trichomoniasis (Trussell), 78
Trussell, R. E., Trichomonas and Trichomoniasis, 79
Tumors, Identification of (Foot), 480
Unipolar Lead Electrocardiography (Goldberger), 308
Vulva, Diseases affecting (Hunt), 371
Wechsler, I. S., Textbook of Clinical Neurology, 268

Weinmann, J. P., Bone and Bones: Fundamentals of Bone Biology, 35
White, B. V., and Geschickter, C. F., Diagnosis in Daily Practice, 122
Wolf, Lulu K., Nursing, 35
Zahorsky, J., Synopsis of Pediatrics, 517
Books published in 1947 by women in medicine, 266
Boucot, Katharine R., Mass Surveys as case-finding techniques for pulmonary neoplasms, 485
Bowles, Doris E., Plastic surgery, 280
Brazil, news from, 429
Brucellosis and its implications (Evans), 229
chronic: fourth most important disease (DeVilbiss) 320
report of a case (Sturgeon), 233

C

Cameron, C. S., Cancer control in United States, 166
Canada, news from, 429
Cancer can be prevented (McGuinness), 173
cervical, progress in diagnosis of (Spitz), 144
chest surveys and other radiologic procedures (McIntosh), 135
control in Denmark (Heise), 164
in Finland (Teittinen), 163
in Turkey, 165
in United States (Cameron), 166
conquest of (Macfarlane), 169
detection and trends in medical practice (Thomas), 508
diagnosis by cytologic test of body fluids (Leslie and Chang), 236
by Papanicolaou smear method (Scapier), 139
progress in (Spitz), 144
technique of taking biopsies (Scharnagel), 142
education (Knowlton), 145
gastric, roentgenoscopic survey for asymptomatic (Sherman), 138
incidence and survival among females in Connecticut (Macdonald), 152
making doctor cancer conscious (Macklin), 147
multiple (Pettit and others), 149
pathogenesis and treatment of, role of sex hormones in (Wiesstien), 186
presymptomatic, what is it? (Macfarlane), 500
prevention clinics, Strang, statistical reports, 132, 134
symposium, 131
Research Congress, Fourth International (Bonser), 24
role of sex hormones in (Wiesstien), 186
statistics (Macdonald), 152
symposium from Strang Clinics, 131
Cardiac crusade (Nicolson), 59
Chang, Helen, and Leslie, Eugenie P., Cytologic test of body fluids in early diagnosis of cancer, 236
Child safety campaign, 361
Childhood, prevention of infectious diseases of (Felton), 46
Children, illegitimate, homes for in occupied Germany (Montreuil-Strauss), 212
United Nations appeal for (Hage), 57
China, news from, 429
Circulation, diseases of (McGovern), 315
Clagett, A. H., Jr., Cardiac surgery, 43
Cleveland, Woman's Hospital of (Pickett), 203
Cold, common, cost of, 55
Copenhagen, BCG vaccinations in (Andersen), 399
Cori, Gerty, M. D., 56, 372
Courage and devotion, 36
Crawford, Mary M., Elise S. L'Esperance, M.D., 311
Cuba, news from, 429
Cushman, Beulah, Value of orthoptics, 100
Cytologic test of body fluids in early diagnosis of cancer (Leslie and Chang), 236
Czechoslovakia, news from, 429

D

Danish Anti-cancer League, 164
Darrow, Anna, prize-winner, 36
Deddish, M., Strang Cancer Clinic, Memorial Hospital, rectal and colon survey, 138
Denmark, cancer control in (Heise), 164
news from, 429
DeVilbiss, Lydia A., Chronic brucellosis, 320
Dingle, Janet T., Premarital consultation, 189
Diseases, infectious, of childhood, prevention of (Felton), 46
of circulation (McGovern), 315
Dodge, Eva F., International Congress of Obstetricians and Gynecologists, 23
Ducker, Marguerite M., Management of physician's office, 116

E

Eckstrom, Dorothy, Strang Cancer Clinic, New York Infirmary, statistical report, 132
Electroencephalography (Schneider), 161
Eliot, Martha, M.D., 424
Endicott, Elizabeth T., Peritoneoscopy, 192
England, Ireland, and Scotland (Gardner), 359
news from, 429
Enlows, Ella M. A., Recent advances in otolaryngology, 195
Etheredge, Maude L., Teaching hygiene in colleges and universities, 41
Evans, Alice C., Brucellosis and its implications, 229
Ewing, J. H., Strang Cancer Clinic, Memorial Hospital, statistical report, men's division, 134

F

Fahimi, Mariam, message from, 25
Felton, Harriet M., Current trends in prevention of infectious diseases of childhood, 46
Fetal membranes, ruptured, diagnosis of (Gray and Roberts), 498
Finland, cancer control in (Teittinen), 163
news from, 430
France, American Women's Hospitals in (Lovejoy), 103
news from, 430
status of medical women in (Odier-Dollfus), 413
From day to day (Reid), 38, 83, 126, 179, 227, 274

G

Gardner, Mabel E., England, Ireland, and Scotland, 359
President's message, 109, 170, 215
President's report, 297
Gastroduodenal disease, biochemical disturbances accompanying (Gray), 389
Gastro-enterology, trends in (Ortmayer), 355
German Medical Women's Association, prewar (Lovejoy), 20
Germany, medical women in (Strecker), 249
news from, 431
news of medical women in, 249
opportunities for physicians in, 520
Gibbons, Marion N., Guest Editor, 206
Gibbons, Marion N., The open mind, the open heart, 206
Goiter, toxic, decline in mortality, 191
Gray, Jessie, Biochemical disturbances accompanying gastroduodenal disease, 389
Guy, May Borquist, Recent advances in pediatrics, 14

H

Hage, Petronella M., United Nations appeal for children, 57
Haiti, news from, 431
Hardy, Marjory K., and Thomas, Carmen C., Bullous skin eruptions following sulfonamide administration, 1
Haymaker, W., and Anderson, Evelyn, Influence of hypothalamus on sexual function, 402, 457
Heart, crusade (Nicolson), 59
surgery (Clagett), 43

Heise, Agnete, Cancer control in Denmark, 164
Helminth ova (Birch), 93
Hematology, International Society of (Birch), 462
Holland, news from, 431
Hormones, sex, in pathogenesis and treatment of cancer (Wiesstien), 186
Hygiene, teaching (Etheredge), 41
Hypothalamus, influence of, on sexual function Anderson and Haymaker), 402, 457
Hysterosalpingography (Jennings), 240

I

India, message from, 250
news from, 431
obstetrical service in (Asirvatham), 411
International Cancer Research Congress (Bonser), 24
International Congress on Mental Health, 407
International Congress of Obstetricians and Gynecologists (Dodge), 23
International Congress on Obstetrics and Gynecology, 194
International correspondents of **Journal**, 427
International interlude (Thelander), 22
International Poliomyelitis Conference (Tenbrinck), 439
International section, 102, 163, 250, 289, 330, 428, 462, 512
International Society of Hematology (Birch), 462
International university, proposal for (Bedarida), 105
Israel, H. L., Present status of streptomycin, 493
Irradiation of human thymus gland, results of (Peters), 87
Italy, news from, 432

J

Japan, opportunities for physicians in, 519
Jennings, Agnes F., Hysterosalpingography, 240

K

Kenyon, Dorothy, United Nations—Hope of the World, 418
Knowlton, Isabel, Education in cancer, 145
Korea, news from, 432
Kovrigina, Maria, 425

L

Lazarus, Dr. Hilda, 250
Leslie, Eugenie P., and Chang, Helen, Cytologic test of body fluids in early diagnosis of cancer, 236
L'Esperance, Elise S., M.D., (Crawford), 310
L'Esperance, Elise S., President's message, 297, 332, 362, 466
Strang Cancer Prevention Clinics, 131
Lewi, Emily, M.D., memorial to, 311
Lindo de Soriano, Yomelda, Neurological complications of whooping cough, 394
Lluberas, Blanca A., Women physicians in Puerto Rico, 103
Longevity of American physicians, 13
Lovejoy, Esther P., American Women's Hospitals in France, 103
American Women's Hospitals in Greece, 106
Pre-war German Medical Women's Association, 20

M

Macdonald, Eleanor J., Incidence and survival picture in cancer among females in Connecticut, 152
Macfarlane, Catharine, M.D., 270
Macfarlane, Catharine, What is presymptomatic cancer? 500
Macklin, Madge T., Making the doctor cancer conscious, 147
Malaria control program, 513
Marriage consultation (Dingle), 189
Martin, Elisabeth, Annie Laurie Sawyer, 80
Martin, Elisabeth, M.D., honored, 178
Mass surveys in case-finding techniques for pulmonary neoplasms (Boucot), 485
McGovern, Teresa, Diseases of circulation, 315
McGuinness, Madge C. L., Cancer can be prevented, 173
McIntosh, Harriet C., Roentgen therapy in shoulder pain, 277
Strang Clinic, New York Infirmary, chest surveys and other radiologic procedures, 135
Medical practice, trends in (Thomas), 508
service, early, of women (Waite), 199
student, predicting success or failure of, 124
Medical woman of the month, 270, 310, 349, 372, 481, 523
Medical women, association of (Ralli), 28
in armed services, status of (Thelander), 253
in France (Odier-Dollfus), 413
Medical Women's International Association, 102
a correction, 360
message from president (Ruys), 19, 425
Medical Women's Library (Van Hoosen), 436, 521
Membranes, diagnosis of ruptured fetal (Taylor and Roberts), 498
Mental health comes alive (Odlum), 407
Mental Health, World Congress on, 58, 407
Mexico, news from, 434
Minoka-Hill, Lillie R., M.D., 272
Montreuil-Straus, G., announcement, 102
Homes for illegitimate babies in Germany, 212
Muhl, Anita, M.D., 271
Mulholland, S. W., Vesical apoplexy, 502
Mycotic diseases (Birch), 48
Myth of a wasted medical education (Thelander), 67

N

Neoplasms, multiple primary (Pettit), 149
pulmonary, mass surveys in case-finding (Boucot), 485
Neurological complications of whooping cough (Lindo de Soriano), 394
Nicolson, Gertrude H. B., Cardiac crusade, 59
Norway, news from, 433

O

OBITUARIES:
Brown, Elizabeth Stow, 272
Gove, Anna M., 178
Greeley, Jane Lincoln, 178
Hilborn, Caroline L., 272
Jennings, Mary Louise, 178
Larimore, Louise D., 483
Lyle, Annie G., 524
Meeker, Louise H., 483
Morgans, Lillian, 272
Norton, Vera L., 483
Povitsky, Olga R., 312
Obstetrical risks (Taylor), 4
service in India (Asirvatham), 411
Obstetricians and Gynecologists, International Congress of (Dodge), 23; 194
O'Connor, Katheryn L., Sarcoidosis (Boeck), 504
Odier-Dollfus, Medical women in France, 413
Odlum, Doris, Mental health comes alive, 407
Open mind—open heart (Gibbons), 206
Opportunities for medical women, 28, 67, 114, 172, 218, 220, 255, 300, 337, 364, 469, 518, 520
Orthoptics, value of (Cushman), 100
Ortmayer, Marie, Trends in gastro-enterology, 355
Otolaryngology, advances (Enlows), 195

P

Pakistan, news from, 433
Papanicolaou smear method (Leslie and Chang, 236 (Scapier), 139
Pearce, Louise, M.D., 523
Pediatrics, prevention of infectious diseases of childhood (Felton), 46
recent advances in (Guy), 14
Peritoneoscopy (Endicott), 192
Peters, M. Vera, Results or irradiation of human thymus gland, 87

Pettit, Mary D., Multiple primary neoplasms, 149
Phelps, Doris, M.D., 271
Philippines, news from, 433
Physician's office, management of (Ducker), 116
Pickett, Frances E., Woman's Hospital of Cleveland, 203
Plastic surgery (Bowles), 277
Platyhelminthes (Birch), 6
Poinso-Chapuis, Germaine, 422
Poliomyelitis Conference, First International (Tenbrinck), 439
Premarital consultation (Dingle), 189
Preston, Ann: Physician (Sturgis), 509
Professional privilege (Tucker), 69
Public health nurse (Baumgartner), 107
Public relations, 69, 116, 173, 218
Publications, current, of medical women, 31, 74, 120, 175, 221, 258, 301, 339, 367, 472, 514
Puerto Rico, women physicians in (Lluberas), 103
Pulmonary neoplasms, mass surveys (Boucot), 485

R

Radiation of human thymus gland (Peters), 87
Rajkumari Amrit Kaur, 423
Ralli, Elaine P., Association of medical women, 28
Opportunities for women in medicine, 218
Rectum, cancer of (Deddish), 138
Reed, Faith W., National Conference on Education, 482
Reid, Ada Chree
Notable record of service, 507
United Nations day, 417
Riddle, Mary-Madeleine, Action is a remedy, 118
Roberts, Joan M., Diagnosis of ruptured fetal membranes, 498
Roentgen therapy in shoulder pain (McIntosh), 277
Roentgenoscopic survey for asymptomatic gastric cancer (Sherman), 136
Ruys, A. Ch., Message from, 19, 425
Visit to the United States, 289

S

Sarcoidosis (Boeck), (O'Connor), 504
Sawyer, Annie Laurie, M.D. (Martin), 80
Scapier, J., Diagnosis of cancer by Papanicolaou smear method, 139
Scharnagel, Isabel M., Diagnosis of cancer, technique of biopsies, 142
Schneider, Linda T., Electroencephalography, 181
Scott, K. Frances, M.D., 481
Scudder, Ida S., M.D., 250
Sex hormones in pathogenesis and treatment of cancer (Wiesstien), 186
Sexual function, influence of hypothalamus on (Anderson and Haymaker), 402, 457
Sherman, R. S., Roentgenoscopic survey for asymptomatic gastric cancer, 136
Shoulder pain, roentgen therapy in (McIntosh), 277
Smear, vaginal, technique, Papanicolaou (Leslie and Chang), 236
(Scapier), 239
simplified (Taylor and Roberts), 498
Spitz, Sophie, Diagnosis of cervical cancer, 144
Steichen, Mary, World Health Association, 421, 464
Strang Cancer Prevention Clinics, symposium on (L'Esperance and others), 131
Strecker, Gabrielle, Medical women in Germany, 249
Women and peace, 415
Streptomycin, present status of (Israel), 493
Sturgeon, H. Violet, Brucellosis, report of a case, 233
Sturgis, Margaret C., Ann Preston: Physician, 509
Sulfonamide, skin eruptions following (Thomas and Hardy), 1
Surgery, cardiac (Clagett), 43
Surgery, plastic (Bowles), 277
Switzerland, news from, 433

T

Taussig, Helen B., M.D., receives award, 349
Taylor, Ann Gray, Obstetrical risks, 4
Diagnosis of ruptured fetal membranes, 498
Teaching hygiene in college (Etheredge), 41
Teittinen, Aino, Cancer control in Finland, 163
Tenbrinck, Margaret S., First International Poliomyelitis Conference, 439
Thelander, H. E., Busman's holiday, 518
International interlude, 22
Myth of a wasted medical education, 67
Status of medical women in armed services, 255
Therapy, recent advances
IV. Pediatrics (Guy), 14
V. Anesthesia (Wells), 53
VI. Orthoptics (Cushman), 100
VII. Otolaryngology (Enlows), 195
VIII. Hysterosalpingography (Jennings), 240
IX. Plastic surgery (Bowles), 280
X. Gastroenterology (Ortmayer), 355
XI. Influence of hypothalamus on sexual function (Anderson and Haymaker), 402, 457
Thomas, Carmen C., Guest Editor, 507
Thomas, Carmen C., Cancer detection and trends in medical practice, 508
Thomas, Carmen C., and Hardy, Marjory K., Bullous skin eruptions following sulfonamide, 1
Thymus gland, human, irradiation of (Peters), 87
Tropical medicine (Birch)
XV. Platyhelminthes, 6
XVI. Trematodes, 8
XVII. Mycotic diseases, 48
Suppl. Helminth ova and arthropods, 93
Tuberculosis, BCG vaccinations in Copenhagen (Andersen), 399
campaign against, 512
Tucker, B. Fain, Professional privilege, 69
Tumors, pulmonary, mass surveys in case-finding (Boucot), 485
Turkey, cancer control in, 165
news from, 433

U

United Nations appeal for children (Hage), 57
United Nations Day (Reid), 417
United Nations—Hope of the world (Kenyon), 418
United Nations World Health Organization, 209, 419
United States, cancer control in (Cameron), 166

V

Van Hoosen, Bertha, Medical Women's Library, 436.
Veterans Administration, opportunities for medical women with, 469

W

Waite, F. C., Early medical service of women, 199
Wells, Lois L., Recent advances in anesthesia, 53
Whooping cough, neurological complications of (Lindo de Soriano), 394
Wiesstien, Bessie G., Role of sex hormones in pathogenesis and treatment of cancer, 186
Woman's Hospital of Cleveland (Pickett), 203
Woman's Hospital of Philadelphia, 124
Woman's Medical College of Pennsylvania, 225, 270, 273, 311, 352, 482.
Women and peace (Strecker), 415
Women, early medical service of (Waite), 199
World Health Association Assembly, First, 248, 421
World Health Organization, 209, 247, 293, 328, 419
World Medical Association, 19, (Bauer) 426
World Medical Association Assembly (Steichen), 464

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